



# **EPIDEMIOLOGIC TRENDS IN DRUG ABUSE**

Proceedings of the Community  
Epidemiology Work Group

**Volume I**  
**Highlights and Executive Summary**

June 2010

NATIONAL INSTITUTE ON DRUG ABUSE



COMMUNITY EPIDEMIOLOGY WORK GROUP

# EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community  
Epidemiology Work Group

**Volume I**

## Highlights and Executive Summary

June 2010

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

Division of Epidemiology, Services and Prevention Research

National Institute on Drug Abuse

6001 Executive Boulevard

Bethesda, Maryland 20892

The National Institute on Drug Abuse (NIDA) acknowledges the contributions made by the representatives of the Community Epidemiology Work Group (CEWG), who prepare the reports presented at the semiannual meetings. Appreciation is extended also to other participating researchers and Federal officials who contributed information. This publication was prepared by Social Solutions International, Inc., under contract number HHSN-2712007-000003C from the National Institute on Drug Abuse.

The information presented in this Executive Summary is primarily based on CEWG area reports and meeting presentations prepared by

CEWG representatives for the June 2010 CEWG meeting. Data/information from Federal sources supplemental to the meeting presentations and discussions have been included in this report to facilitate cross-area comparisons.

All material in this report is in the public domain and may be reproduced or copied without permission from the Institute or the authors. Citation of the source is appreciated. The U.S. Government does not endorse or favor any specific commercial product. Trade or proprietary names appearing in this publication are used only because they are considered essential in the context of the studies reported herein.

***For more information about the Community Epidemiology Work Group and other research-based publications and information on drug abuse and addiction, visit NIDA's Web site at <<http://www.drugabuse.gov>>.***

***This report (available in limited supply) can be obtained by contacting the NIDA DrugPubs Research Dissemination Center***

***by phone:***        **877-NIDA-NIH (877-643-2644)**  
                         **240-645-0228 (TTY/TDD)**

***by fax:***            **240-645-0227**

***by email:***        **[drugpubs@nida.nih.gov](mailto:drugpubs@nida.nih.gov)**

# Contents

<b>Foreword</b> .....	iv
<b>Section I. Introduction</b> .....	1
<b>Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the June 2010 CEWG Meeting</b> .....	8
<b>Section III. Across CEWG Areas: Treatment Admissions and Forensic Laboratory Analysis Data</b> .....	58
Cocaine/Crack .....	58
Heroin .....	65
Opiates/Opioids Other Than Heroin (Narcotic Analgesics) .....	72
Benzodiazepines/Depressants .....	78
Methamphetamine .....	80
Marijuana/Cannabis .....	87
Club Drugs (MDMA, MDA, GHB, LSD, and Ketamine) .....	93
PCP (Phencyclidine) .....	96
Other Drugs (Including BZP, TFMPP, Foxy Methoxy, Psilocin/Psilocybin, and Carisoprodol) .....	97
<b>Appendix Tables</b> .....	99
Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, and CEWG Area: FY 2009 and CY 2009 .....	99
Appendix Tables 2.1–2.22. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 22 CEWG Areas: January–December 2009 .....	101
<b>Participant List</b> .....	107

# Foreword

**THIS EXECUTIVE SUMMARY PROVIDES A SYNTHESIS OF** findings from reports presented and data prepared for the 68th semiannual meeting of the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG) held in Boston, Massachusetts, on June 9–11, 2010. The CEWG is a network of researchers from sentinel sites throughout the United States. It meets semiannually to provide ongoing community-level public health surveillance of drug abuse through presentation and discussion of quantitative and qualitative data. CEWG representatives access multiple sources of existing data from their local areas to report on drug abuse patterns and consequences in their areas and to provide an alert to potentially emerging new issues. Local area data are supplemented, as possible, with data available from federally supported projects, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN), Drug Enforcement Administration (DEA) National Forensic Laboratory Information System (NFLIS), and the DEA Heroin Domestic Monitor Program (HDMP). This descriptive and analytic information is used to inform the health and scientific communities and the general public about the current nature and patterns of drug abuse, emerging trends, and consequences of drug abuse.

The CEWG convenes twice yearly, in January and June. For the June meetings, CEWG representatives prepare full reports on drug abuse patterns and trends in their areas. After the meeting, a *Highlights and Executive Summary Report* is produced, and the full CEWG area reports are included in a second volume.

The majority of the June 2010 meeting was devoted to the CEWG area reports and presentations. CEWG area representatives presented data on local drug abuse patterns and trends. Presentations on drug abuse patterns and issues were also provided by guest researchers from Canada, the Netherlands, Mexico, New Zealand, and the

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, Portugal. Other highlights of the meeting included a welcome from Rita Nieves, R.N., M.P.H., M.S.W., Director of the Addictions Prevention, Treatment, and Recovery Support Services Bureau in Boston; a greeting and update from Wilson Compton, M.D., M.P.E., Director of the Division of Epidemiology, Services, and Prevention Research at NIDA; presentations by DEA representatives Cassandra Prioleau, Ph.D., and Artisha Polk, M.P.H., on NFLIS and emerging drugs of concern and drug scheduling issues; an update from the Office of National Drug Control Policy on the Arrestee Drug Abuse Monitoring (ADAM) II data system by M. Fe Caces, Ph.D.; and an update on the National Drug Intelligence Center's SENTRY from Susan Seese, Ph.D. A panel session on new drugs included a presentation on "Adulterants, Drugs, Coingestants, and Associated HIV Risks" from Edward Boyer, M.D., Ph.D., Professor, Department of Emergency Medicine at the University of Massachusetts Medical School; a presentation on "Epidemiology, Clinical Effects, and Testing Results from a K2 Outbreak" by Christopher Rosenbaum, M.D., from the Division of Medical Toxicology, Department of Emergency Medicine, University of Massachusetts Medical Center; a presentation on "BZP Use in New Zealand: Patterns of Use, Harms, and Policy Response" from Chris Wilkins, Ph.D., Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland, New Zealand; and one by Paul Griffiths, Scientific Coordinator for the EMCDDA in Portugal on the European Union's Early Warning System on new synthetic psychoactive substances, including the current situation and future challenges, using the synthetic cathinone, mephedrone, as a case study. An epidemiologic surveillance methods panel session included the following three presentations: "Use of Arrestee Data to Monitor Drug Abuse," by Eric Wish, Ph.D., Director of the Center for Substance

Abuse Research at the University of Maryland; “Using Treatment Admissions Data for Monitoring Methamphetamine,” by James Cunningham, Ph.D., the CEWG Phoenix area representative; and “Epidemiologic Surveillance Systems Development,” by Caleb Banta-Green, Ph.D., M.P.H., M.S.W., the CEWG area representative from Seattle.

The Proceedings of the Community Epidemiology Work Group for the June 2010 CEWG meeting are published in two volumes. This volume highlights findings across CEWG areas. Full local area

and international reports are presented in Volume II. Readers of this report are directed to Volume II for a more detailed description of data sources and presentation of data from the CEWG areas.

*Moiria P. O’Brien*

Division of Epidemiology, Services and  
Prevention Research  
National Institute on Drug Abuse  
National Institutes of Health  
Department of Health and Human Services

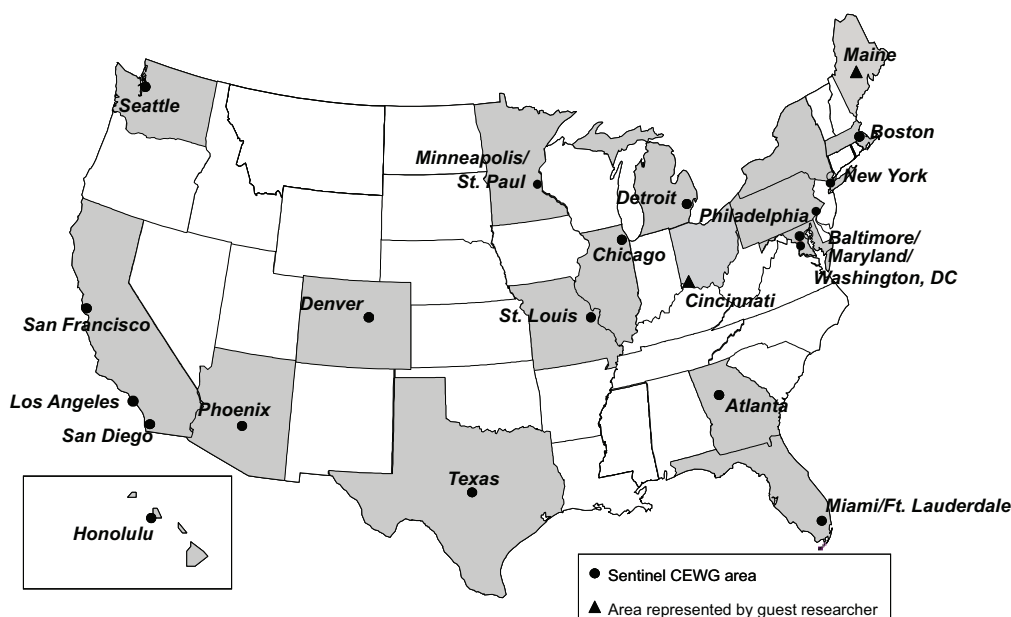
# Section I. Introduction

THE 68TH SEMIANNUAL MEETING OF THE COMMUNITY Epidemiology Work Group (CEWG) was held on June 9–11, 2009, in Boston, Massachusetts. During the meeting, researchers from 22 geographically dispersed areas in the United States reported on current trends and emerging issues in their areas. In addition to the information provided for 18 sentinel areas that have contributed to the network for many years and two additional areas (Colorado and Broward County, Florida in the Miami/Dade Metropolitan Statistical Area [MSA]), guest researchers from Cincinnati and Maine provided data from their respective areas. International representatives from Canada, the Netherlands, Mexico, and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, Portugal, reported on drug abuse trends and issues in their respective countries and the European Union, and a New Zealand researcher gave a presentation on BZP (1-benzylpiperazine) use in that country.

## The CEWG Network

The CEWG is a unique epidemiology network that has functioned since 1976 as a drug abuse surveillance system to identify and assess current and

emerging drug abuse patterns, trends, and issues, using multiple sources of information. Each source provides information about the abuse of particular drugs, drug-using populations, and/or different facets of the behaviors and outcomes related to drug abuse. The information obtained from each source is considered a drug abuse *indicator*. Typically, indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be increasing or decreasing in size. However, indicators do help to characterize drug abuse trends and different types of drug abusers (such as those who have been treated in hospital emergency departments, admitted to drug treatment programs, or died with drugs found in their bodies). Data on items submitted for forensic chemical analysis serve as indicators of availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility, and potency of specific drugs. Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas. The CEWG





areas on which presentations were made at the June 2010 meeting are depicted in the map above, with one presentation including data on the Baltimore/Maryland/Washington, DC, area.

## CEWG Meetings

The CEWG convenes semiannually; these meetings continue to be a major and distinguishing feature of the workgroup. CEWG representatives and guest researchers present information on drug abuse patterns and trends in their areas, and personnel from Federal agencies provide updates of data sets used by the CEWG. In addition, time is set aside for question-and-answer periods and discussion sessions. The meetings provide a foundation for continuity in the monitoring and surveillance of current and emerging drug problems and related health and social consequences.

Through the meetings, the CEWG accomplishes the following:

- Dissemination of the most up-to-date information on drug abuse patterns and trends in each CEWG area
- Identification of changing drug abuse patterns and trends within and across CEWG areas

At the semiannual meetings, CEWG representatives address issues identified in prior meetings and, subsequently, identify drug abuse issues for follow-up in the future.

In addition to CEWG area presentations, time at each meeting is devoted to presentations by invited speakers. These sessions typically focus on the following:

- Presentations by researchers in the CEWG host city
- Updates by Federal personnel on key data sets used by CEWG representatives
- Drug abuse patterns and trends in other countries

Identification of changing drug abuse patterns is part of the discussions at each CEWG meeting. Through this process, CEWG representatives can alert one another to the emergence of a potentially

new drug of abuse. The CEWG is uniquely positioned to bring crucial perspectives to bear on urgent drug abuse issues in a timely fashion and to illuminate their various facets within the local context through its semiannual meetings and post-meeting communications.

## Data Sources

To assess drug abuse patterns and trends, city- and State-specific data were compiled from a variety of health and other drug abuse indicator sources. Such sources include public health agencies; medical and treatment facilities; ethnographic research; key informant discussions; criminal justice, correctional, and other law enforcement agencies; surveys; and other sources unique to local areas.

Availability of data varies by area, so reporting varies by area. Examples of types of data reviewed by CEWG representatives to derive drug indicators include the following:

- Admissions to drug abuse treatment programs by primary substance of abuse or primary reason for treatment admission reported by clients at admission
- Drug-involved emergency department (ED) reports of drugs mentioned in ED records in the Drug Abuse Warning Network (DAWN) *Live!* data system, along with weighted estimates from the DAWN system
- Seizure, average price, average purity, and related data obtained from the Drug Enforcement Administration (DEA) and from State and local law enforcement agencies
- Drug-related deaths reported by medical examiner (ME) or local coroner offices or State public health agencies
- Arrestee urinalysis results and other toxicology data
- Surveys of drug use
- Poison control center data

Sources of data used by several or most of the CEWG area representatives and presented in



this *Highlights and Executive Summary Report* are summarized below, along with some caveats related to their use and interpretation. The terminology that a particular data source uses to characterize a drug, for example, cannabis versus marijuana, is replicated here.

**Treatment data** were derived from CEWG area reports. For this report, they represent data for 17 CEWG metropolitan areas and 5 States: Colorado, Hawaii, Maine, Maryland, and Texas. Recent or complete treatment admissions data were not available for Chicago and Washington, DC. Data for some States are included with metropolitan data for comparison, including data for Colorado with Denver. The reporting period is cited as calendar year (CY) 2009 for all of the CEWG areas except Cincinnati and San Francisco, where data were reported for fiscal year (FY) 2009 (July 2008–June 2009). Appendix table 1 shows overall treatment admissions data by drug and CEWG area for the current reporting period. Table 3 in section II and several tables in section III (tables 4–14 and 17–23) also display cross-area treatment admissions data, as do several figures in section II (figures 1, 4, 6, 8, 15, 16, and 18).

**DAWN ED<sup>1</sup> weighted estimates** for 12 CEWG areas for 2004 through 2008 were provided by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). The data represent drug reports for drug-involved visits for illicit drugs (derived from the category of “major substances of abuse,” excluding alcohol) and the nonmedical use of selected pharmaceutical drugs. Nonmedical use of pharmaceuticals is use that involves taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a

pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs, especially illegal drugs or alcohol. Since drug reports exceed the number of ED visits because a patient may report use of multiple drugs (up to six drugs plus alcohol), summing of drugs across categories is not recommended. A description of the DAWN system can be found at <http://DAWNinfo.samhsa.gov>. Several CEWG reports in Volume II include DAWN data: Chicago, Denver, Miami/South Florida, New York City, and San Francisco, as do figures 2 and 19 in section II of this Volume.

**Forensic laboratory data** for a total of 22 CEWG sites were available for CY 2009. Data for all CEWG metropolitan areas in 2009 were provided by the National Forensic Laboratory Information System (NFLIS), maintained by the DEA. NFLIS is a program in the DEA Office of Diversion Control that systematically and continuously collects results from drug analyses of items received from drug seizures by law enforcement authorities. Drug analyses are conducted by Federal (DEA) forensic laboratories and participating State and local forensic laboratories. As of June 2010, in addition to the DEA laboratories, the NFLIS included 47 State systems, 94 local or municipal laboratories/laboratory systems, and 1 territorial laboratory, representing a total of 280 individual laboratories. These laboratories handled more than 88 percent of the Nation’s nearly 1.2 million annual State and local drug analysis distinct cases. Data are entered daily based on seizure date and the county in which the seizure occurred. NFLIS provides detailed information on the prevalence and types of controlled substances secured in law enforcement operations and assists in identifying emerging drug problems and changes in drug

<sup>1</sup>DAWN uses a national sample of non-Federal, short-stay, general surgical, and medical hospitals in the United States that operate 24-hour EDs. The American Hospital Association (AHA) 2001 Annual Survey is the source of the sample. ED medical records are reviewed retrospectively for recent drug use. Visits related to most types of drug use or abuse cases are identified and documented. Drug cases encompass three visit categories: those related to illegal or illicit drugs; nonmedical use of prescription, over-the-counter, or other pharmaceutical drugs; and alcohol among patients under the legal drinking age of 21 and patients of all ages when used in combination with other drugs.

availability and in monitoring illicit drug use and trafficking, including the diversion of legally manufactured drugs into illegal markets. A list of participating and reporting State and local forensic laboratories is included in Appendix A of the U.S. Drug Enforcement Administration, Office of Diversion Control (2009) report, *National Forensic Laboratory Information System: Year 2008 Annual Report* (Washington, DC: U.S. Drug Enforcement Administration)<sup>2</sup>. In most cases, data are for MSAs, rather than single metropolitan counties, but the exact geographic areas covered in this report are defined in appendix table 2. A map displaying NFLIS data for 2009 for 22 CEWG areas is included as figure 22 in section II, while a number of other figures and tables in section II (tables 1 and 2 and figures 5, 9, and 14) and section III (figures 23–26 and tables 15–16 and 24–25), along with appendix tables 2.1–2.22, are provided to display the data on forensic laboratory drug items identified for the period across areas. CEWG area reports in Volume II also include NFLIS data for CEWG areas.

**Illicit drug price data** for heroin for 21 CEWG metropolitan areas in CY 2008 (the most recent period available) came from the DEA report, *2008 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report*, published October 2009 (DEA-09022). This report is prepared by the Domestic Strategic Intelligence Unit of the Special Strategic Intelligence Section and reflects analysis of program data to December 31, 2008. Data from this report are included for the following CEWG sites/areas: Atlanta, Boston, Chicago, Detroit, New York City, Philadelphia, Phoenix, St. Louis, San Francisco, and Texas. Drug prices and trafficking trends also came from the National Drug Intelligence Center's report, *National Illicit Drug Prices—Mid Year 2009*. Data from this report are included for the following CEWG sites/areas: Atlanta, Baltimore/Maryland/Washington, DC, Chicago, Denver, Detroit, Miami/South Florida, New York City, Philadelphia, St. Louis, and San Francisco.

### **DEA ARCOS (Automation of Reports and Consolidated Orders System) data**

were presented by the CEWG area representatives from Baltimore/Maryland/Washington, DC, and Minneapolis/St. Paul in the CEWG full area reports contained in Volume II. ARCOS is an automated, comprehensive drug reporting system that monitors the flow of DEA-controlled substances from their point of manufacture through commercial distribution channels to point of sale or distribution at the dispensing/retail level. The following controlled substance transactions are tracked by ARCOS: all Schedule I and II materials (manufacturers and distributors); Schedule III narcotic and GHB (gamma hydroxybutyric acid) materials (manufacturers and distributors); and selected Schedule III and IV psychotropic drugs (manufacturers only).

**Local drug-related mortality data** from medical examiners/coroners (ME/Cs) or State public health agencies were reported for 17 CEWG areas, namely Atlanta, Baltimore/Maryland/Washington, DC, Chicago, Cincinnati, Denver, Detroit, Honolulu, Maine, Miami/South Florida, Minneapolis/St. Paul, New York City, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, and Texas. These are described in Volume II and shown in figures 3, 10, 13, and 20 in section II of this report.

**Other data** cited in this report were local data accessed and analyzed by CEWG representatives. The sources included the Centers for Disease Control and Prevention (CDC)'s Youth Risk Behavior Surveillance System (YRBSS) and Youth Risk Behavior Survey (YRBS) data; local law enforcement (e.g., data on drug arrests); local DEA offices (DEA field reports); High Intensity Drug Trafficking Area (HIDTA) reports; arrestee drug information from the Arrestee Drug Abuse Monitoring (ADAM) II system; poison control centers and help lines; prescription drug monitoring systems; local and State surveys; and interviews with key informants and ethnographers. Figure 12 in section

<sup>2</sup>This can be found at <https://www.nflis.deadiversion.usdoj.gov/DesktopModules/ReportDownloads/Reports/NFLIS2008AR.pdf>.

II reports poison control call data, while figure 7 displays hospital admissions data; figure 11 reports prescription drug monitoring program data; figure 17 shows YRBS data; and figure 21 displays AIDS data from the CDC.

## A Note to the Reader—Caveats

### Terminology and Geographic Coverage—

The CEWG representatives use existing data, which are subject to the definitions and geographic coverage of the source data. Representatives generally use the terminology as it is used in the data source. For example, many treatment systems use the phrase, “other opiates” for classifying opiates<sup>3</sup> or opioids<sup>4</sup> other than heroin as the primary problem at admission. The term “other opiates” is therefore retained in this summary report, and the terms, “other opiates” and “opioids” may be used in a single area report. Similarly, the term, “prescription-type opioid,” is used by some representatives to distinguish synthetic or semisynthetic opioids, such as oxycodone and hydrocodone, from heroin. The geographic coverage of data sources may vary within a CEWG area report. Readers are directed to the Volume II full CEWG area reports for a more complete description of data sources used in specific areas. In this summary report, in most cases, the general name of the CEWG area will be used for data sources. For the DAWN and NFLIS data, the specific geographic coverage will be noted in footnotes. For example, appendix table 2 presents the NFLIS data for each area and footnotes specify the coverage.

Local comparisons are limited, or must be made with caution, for the following indicators:

**Treatment Admissions**—Many variables affect treatment admission numbers, including program emphasis, capacity, data collection methods, and reporting periods. Therefore, changes in

admissions bear a complex relationship to drug abuse prevalence. Treatment data on primary abuse of specific drugs in this report represent percentages of total admissions, both including and excluding primary alcohol admissions. Percentage distributions based on total treatment admissions by drug, including primary alcohol admissions, were used for all cross-area comparisons. Data on demographic characteristics (gender, race/ethnicity, and age group) and route of administration of particular drugs were provided for most CEWG areas and reported in full area reports. The numbers of admissions for alcohol and other drugs in 2009 are presented for 22 reporting CEWG sites/areas in appendix table 1, with rankings documented in section II, table 3. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers are subject to change. Most of the CEWG area representatives report Treatment Episode Data Set (TEDS)<sup>5</sup> data accessed from local treatment programs or States, and these data are included in cross-area comparison tables in this report (section II, table 3; section III, tables 4–14 and 17–23; and appendix table 1).

**ED Drug Reports**—For this meeting report, weighted estimate data were provided to area representatives by OAS, SAMHSA, from the DAWN system for 2004–2008, with statistical tests of differences using *t*-tests and *p*-values. These data were used in full area reports by 5 of the 11 area representatives for whom such data were available in the DAWN system. These areas are Chicago, Denver, Miami/South Florida, New York City, and San Francisco. Some area representatives reported weighted DAWN data in their January 2010 Update Briefs and abstracts and did not include those data in the full area reports for June 2010. When comparisons are made across

<sup>3</sup>Opiate is defined as “any preparation or derivative of opium” by *Stedman’s Medical Dictionary – 28th Edition*, Lippincott Williams and Wilkins, Baltimore, MD: c. 2006.

<sup>4</sup>Opioid is defined as “originally a term denoting synthetic narcotics resembling opiates but increasingly used to refer to both opiates and synthetic narcotics” by *Stedman’s Medical Dictionary – 28th Edition*, Lippincott Williams and Wilkins, Baltimore, MD: c. 2006.

<sup>5</sup>TEDS is an administrative data system providing descriptive information about the national flow of admissions to specialty providers of substance abuse treatment, conducted by OAS, SAMHSA.

time periods within a CEWG area, this caveat is needed: statements about drug-involved ED weighted rates in CEWG areas being higher or lower in 1 year than another year are only made when their respective *t*-test *p*-values are significant at the .05 level or below. Otherwise, no difference is reported<sup>6</sup>.

**Forensic Laboratory Drug Items Identified**—NFLIS data include drug chemistry results from completed analyses only; drug evidence secured by law enforcement but not analyzed in laboratories is not included in the NFLIS database. State and local policies related to the enforcement and prosecution of specific drugs may affect drug evidence submissions to laboratories for analysis. Laboratory policies and procedures for handling drug evidence vary and range from analysis of all evidence submitted to the laboratory to analysis of selected items only. Many laboratories did not analyze the evidence when a case was dismissed or if no defendant could be identified (see NFLIS 2008 Report cited earlier). Differences in local/State laboratory procedures and law enforcement practices across areas make area comparisons inexact. Also, the data cannot be used for prevalence estimates, because they are not adjusted for population size.

NFLIS data report the percentage that each drug represents of the total number of drug items seized and identified by forensic laboratories in a CEWG area, and cases are assigned to a geographic area by the location of the seizure event, not the laboratory. Because the method of case assignment for the data provided by DEA to the

CEWG has changed recently to assignment based on the geographic location from which items were submitted for identification, rather than the location of the laboratory that performed the item identification, 2007, 2008, and 2009 NFLIS data cannot be compared with pre-2007 data presented in prior CEWG reports. The nature of the NFLIS reporting system is such that there may be a time lag between the time of seizure, the time of analysis of drug items, and the time of reporting to the NFLIS system. Therefore, differences in the number of drug items for a specified time period may occur when NFLIS is queried at different times, since data input is daily and cases may be held for different periods of time before analysis and reporting in various areas and agencies. Numbers of drug items presented in these reports are subject to change and may differ when drawn on different dates. Not all forensic laboratories report on substances that are not controlled, rendering some comparisons of such drugs inaccurate.

**Deaths**—Mortality data may represent the presence of a drug detected in a decedent or overdose deaths. The mortality data are not comparable across areas because of variations in methods and procedures used by ME/Cs. Drugs may cause a death, be detected in a death, or simply relate to a death in an unspecified way. Multiple drugs may be identified in a single case, with each reported in a separate drug category. Definitions associated with drug deaths vary. Common reporting terms include “drug-related,” “drug-detected,” “drug-induced,” “drug-caused,” and “drug-involved.” These terms may have different meanings in

<sup>6</sup>Estimates of ED visits associated with misuse and abuse of drugs are derived by applying sampling weights to data from a stratified probability sample of hospitals. The estimates obtained are of drug-involved visits. A single ED visit may involve multiple drugs, which are counted separately. When ED visits involve multiple drugs, such visits appear multiple times in a table. Therefore, summing ED visits as reported in these tables will produce incorrect and inflated counts of ED visits. Combining estimates for categories of drugs is subject to a similar limitation. Multiple drugs may be involved in a single visit, so categories are not mutually exclusive and will not sum to 100 percent when percentages are calculated. Because multiple substances may be recorded for each DAWN case, caution is necessary in interpreting the relationship between a particular drug and the number of associated visits. It is important to note that a drug-involved ED visit is any ED visit related to recent drug use. This is the new definition of a DAWN case as of 01/01/03. One or more drugs have to be implicated only in the visit; they do not necessarily have to have precipitated or caused the visit. These are visits, not patients, such that they are duplicated numbers to an unknown extent rather than being unique numbers. See: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Drug Abuse Warning Network, 2007: National Estimates of Drug-Related Emergency Department Visits*. Rockville, MD, 2010. Available at <http://DAWNinfo.samhsa.gov>.



different areas of the country, and their meaning may depend upon the local reporting standards and definitions. Cross-area tabulations of mortality drug abuse indicators are not included in this report.

**Arrest and Seizure Data**—The numbers of arrests and quantities of drugs seized may reflect enforcement policy and resources, rather than level of abuse.

## Local Area Comparisons

The following methods and considerations pertain to local area comparisons:

- Local areas vary in their reporting periods. Some indicators reflect fiscal periods that may differ among local areas. In addition, the timelines of data vary, particularly for death and treatment indicators. Spatial units defining a CEWG area may also differ depending on the data source. Care has been taken to delineate the definition of the geographic unit under study for each data source, whether a city, a single metropolitan county, an MSA, or some subset of counties in an MSA. In some instances, data were compiled by region defined by the U.S. Census as northeastern, southern, midwestern, and western regions. Texas is included in the western region in this report, rather than in the census-defined southern region, based on member recommendations concerning area comparability of drug patterns and similarity of population characteristics to other western areas.
- In section III of this report, percentages for treatment program admissions are calculated and presented in two ways: excluding primary alcohol admissions from the total on which the percentages are based and including primary alcohol admissions in the total on which percentages are based. However, all cross-area comparisons use only the latter measure, with the exception of tables 7, 11, 14, 20, and 23, which show changes in treatment admissions over the 5-year period from 2005 to 2009, where data were available, and exclude primary alcohol treatment admissions from denominators.
- Nearly all treatment data in the cross-area comparison section of this report cover January through December 2009, which is characterized as the current reporting period. However, Cincinnati and San Francisco reported FY 2009 data (July 2008–June 2009).
- Some indicator data are unavailable for certain cities. Therefore, the symbol, “NR,” in tables refers to data not reported by the CEWG area representative.
- The population racial/ethnic composition differs across CEWG areas. Readers are directed to the individual CEWG full area reports in Volume II of this report for information regarding treatment patterns and trends pertaining to race/ethnicity, age, and gender.

## Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the June 2010 CEWG Meeting

THE CORNERSTONE OF THE CEWG MEETING IS THE CEWG area report. Area representatives provide 20-minute presentations summarizing the most recent data pertaining to illicit and abused drugs and noting changes since the prior meeting. These data are viewed as indicators of the drug problem in an area. Indicators reflect different aspects of the drug abuse situation in an area, such as prevalence of abuse of drugs (e.g., survey findings), consequences of drug abuse (e.g., drug-involved ED reports, substance abuse treatment admissions, and drug-related deaths), and availability of abused substances or law enforcement engagement (e.g., drug seizures). Qualitative information from ethnographic studies or local key informants is also used to describe drug use patterns and trends, and it may be particularly informative in the early identification of new issues or substances being misused or abused.

In presenting area reports, CEWG representatives are invited to use their professional judgment and knowledge of the local context to provide an overall characterization of the indicators for their areas, as possible, given available data; that is, to assess whether indicators appear to be stable, increasing, decreasing, or are mixed so that no consistent pattern is discernable. CEWG representatives may also provide an overall characterization of the level of the indicators as high, moderate, or low, or identify when particular drugs are considered to be the dominant drugs of abuse in an area. Some indicators are sensitive to recent changes in local policy or law enforcement focus; therefore, representatives use their knowledge of the local context in describing and interpreting data available for their area.

Abstracts and full area reports reflecting the CEWG area presentations are included in Volume II of this report. Area reports document and

summarize drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the January 2010 and June 2009 meeting reports. The availability of data varies by area. Readers are directed to the Data Sources section of the Volume II reports to determine which data sources were reviewed for particular areas.

Subsequent to the CEWG meeting, data available across a majority of CEWG areas, such as substance abuse treatment admissions and information from NFLIS, are reviewed. These data are presented in section III of this report and in appendix tables 1 and 2.1–2.22. Highlights from these cross-area tabulations are also included in this section.

For the June 2010 CEWG meeting, CEWG representatives were invited to provide an overview and update on drug abuse trends in their areas for the most recent calendar year (2009). Key findings and issues identified at the CEWG meeting are highlighted in section II, with more detail provided in Volume II.

Findings in this report are summarized by type of substance, but it is important to note that poly-substance abuse continues to be a pervasive pattern across all CEWG areas.

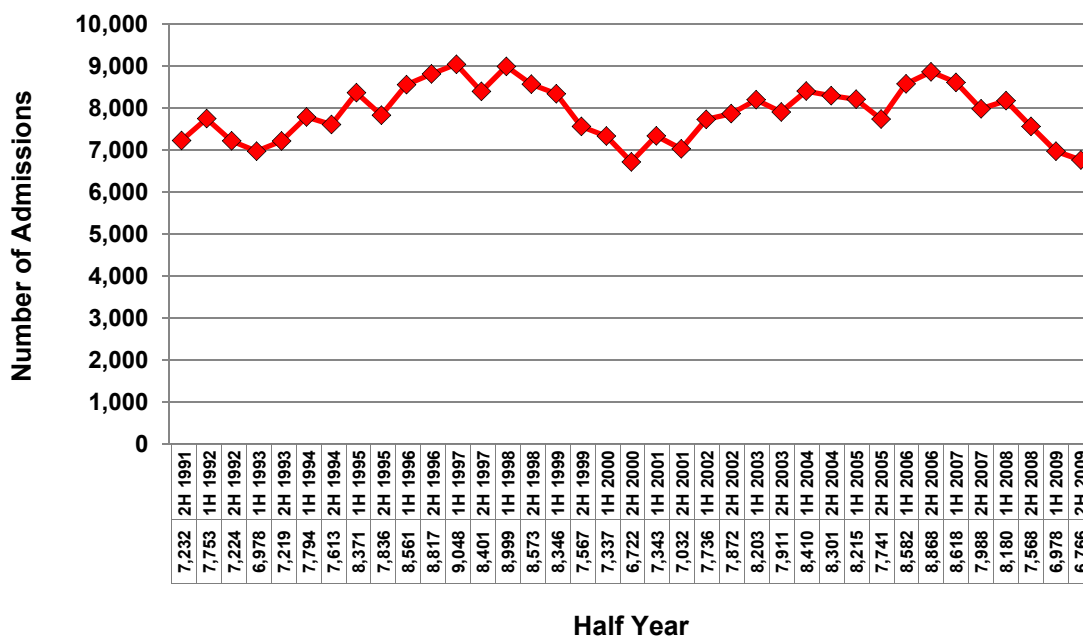
### Cocaine/Crack

- *Cocaine remained a major drug of concern in all of the CEWG regions—the Northeast, South, Midwest, and West—based largely on NFLIS and treatment admissions indicators. However, the decline in cocaine indicators reported by several area representatives at recent CEWG meetings continued into this reporting period. Cocaine indicators were down in all eight areas in the West, in all four areas in the Northeast, in two of the three areas in the South (the exception*

*was the Baltimore/Maryland/Washington, DC, area), and in three of the five areas in the Midwest (where the exceptions were the Minneapolis/St. Paul area and Detroit). Cocaine indicators remained high and stable in Chicago; they were mixed in all of the other CEWG areas.*

- Cocaine indicators remained high throughout the northeastern region.
  - In Boston, the area representative reported a decrease in cocaine primary substance abuse treatment admissions, driven by a sharp decrease in the number of crack admissions (from 1,068 in 2008 to 779 in 2009). This decline occurred despite continuing high cocaine treatment levels relative to other drugs.
  - The area representative from Maine reported that while cocaine indicators remained high they have decreased since 2007. Of particular note was the decrease in deaths attributed to cocaine.
- While still high and mixed in New York City, several cocaine indicators had decreased substantially, according to that area representative. Primary cocaine treatment admissions declined in New York City to the lowest level in more than two decades, but more clients in treatment had a primary, secondary, or tertiary problem with cocaine than with any other drug (figure 1).
- In Philadelphia, cocaine indicators continued to decline in several areas, including the proportion of treatment admissions, the number of mortality cases, and the percentage of Adult Probation/Parole Department cocaine-positive urine drug screens, according to the area representative. However, cocaine remained the most detected drug in decedents in Philadelphia.
- Similarly, cocaine indicators continued to be reported as high but declining in the southern region.

**Figure 1. Number of Treatment Admissions with Cocaine as the Primary Problem Substance, New York City: Semiannually, 2H 1991 to 2H 2009**

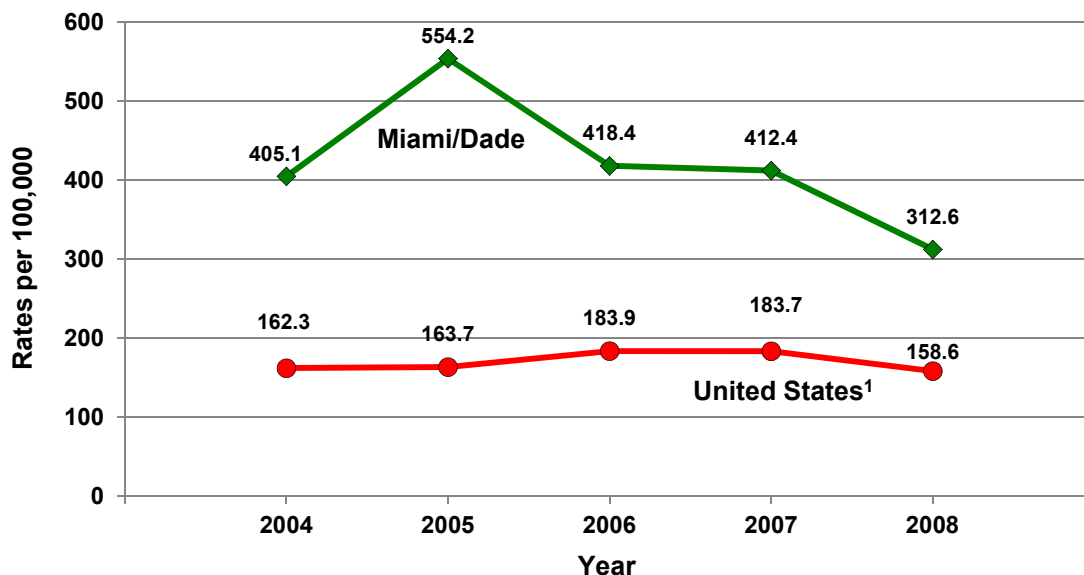


SOURCE: New York State Office of Alcoholism and Substance Abuse Services (OASAS), as reported by Rozanne Marel at the June 2010 CEWG meeting



- Cocaine remained the dominant drug in Atlanta, along with marijuana/cannabis, but most indicators pointed to a reduction in the drug's use. For example, cocaine accounted for 48.7 percent of confiscated substances tested in NFLIS forensic laboratories in 2009, compared with 55.9 percent in 2008. Nevertheless, cocaine was still the most frequently identified drug among items seized in the NFLIS system in Atlanta.
- The Baltimore/Maryland/Washington, DC, area representative reported that cocaine continued to be one of the most serious problems in that area. While decreases in both adult and juvenile arrestees testing positive for cocaine were reported in January 2010, the area representative reported that the downward trend was reversing. The percentage of adult arrestees testing positive for cocaine had increased in the most recent data for the area (31.4 percent for January–April 2010, compared with 28.7 percent in 2009 and 33.0 percent in 2008).
- Notable decreases in cocaine indicators were reported by the Miami area representative, continuing a 3-year decline. However, the area representative reported that cocaine consequences still dominated those of other drugs and remained higher in both Miami/Dade and Broward Counties than in most of the Nation's metropolitan areas. Figure 2 shows that estimated rates of weighted cocaine-involved ED visits fell in Miami/Dade County from a high of 554.2 per 100,000 population in 2005 to 312.6 per 100,000 in 2008 (It is not known whether this difference is statistically significant, because significance testing for 2005 and 2008 was not available from the data source).
- Cocaine indicators across the Midwest were mixed. They remained high in Chicago and

**Figure 2. Estimated Rates of Cocaine Emergency Department Visits Per 100,000 Population, Miami/Dade County and the United States: 2004–2008**



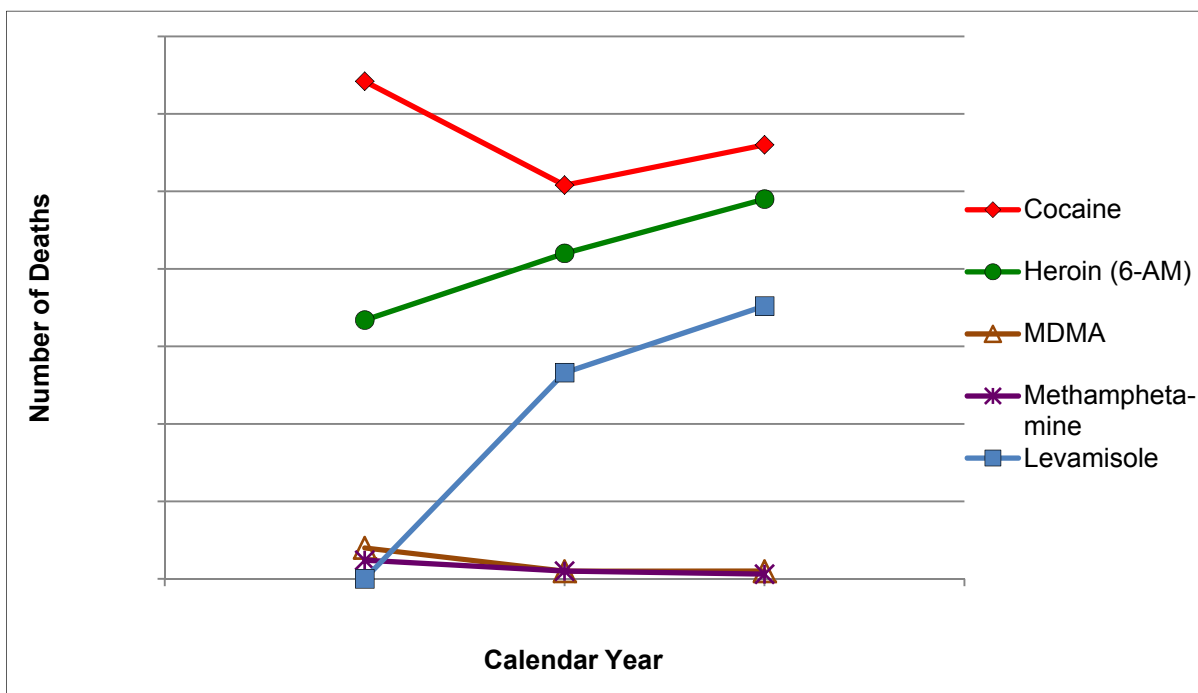
<sup>1</sup>Rates declined by a statistically significant 13 percent from 2007 to 2008 in the United States, although no statistically significant rate changes were noted for Miami/Dade for 2004, 2006, and 2007 compared with 2008. No significance testing of data for 2005 versus 2008 was available.

SOURCE: OAS, SAMHSA; weighted DAWN ED estimates and rates, received 5/12/10, as reported by James Hall at the June 2010 CEWG meeting

Detroit and moderate and declining in the Minneapolis/St. Paul area, St. Louis, and Cincinnati.

- In Chicago, the area representative reported that results of the 2009 YRBS survey showed the percentage of Chicago high school students reporting ever using cocaine was the highest since 2003 (at 6.7 percent).
- In 2009, the Detroit area representative reported data from the Wayne County Medical Examiner (Detroit) showing 280 deaths involving cocaine, the highest number for all drugs in that area, and an increase over the 254 deaths attributed to cocaine in 2008 (figure 3).
- The Minneapolis/St. Paul area representative reported marked declines in treatment admissions for cocaine in 2009 (6.4 percent of total addiction treatment admissions, compared with 9.9 percent of such admissions in 2008). In addition, cocaine-related deaths fell sharply, from 59 deaths in 2007,
- to 21 deaths in 2008, and down to 10 deaths in 2009.
- In St. Louis, crack cocaine, which had been the major stimulant problem in the area, decreased in availability and in most indicators. Deaths involving cocaine dropped in St. Louis, from 167 in 2007 to 70 in 2009.
- Although cocaine indicators remained at high levels in several areas in the West (Denver, San Francisco, and Seattle), all area representatives from that region reported declining cocaine indicators. Cocaine indicators were reported as decreasing in Denver, Los Angeles, Phoenix, Seattle, and Texas. In San Francisco, where cocaine levels were high, the area representative reported a continuing gradual decline in indicators, along with an increase in older users. In San Diego, cocaine indicators continued to decline from previous reporting periods, and prevalence of use among arrestees (measured by urinalysis) reached its lowest point since 2000, at 7,

**Figure 3. Number of Deaths with Laboratory-Confirmed Presence of Selected Drugs, Including Cocaine and Levamisole, Wayne County (Detroit Area): 2007–2009**



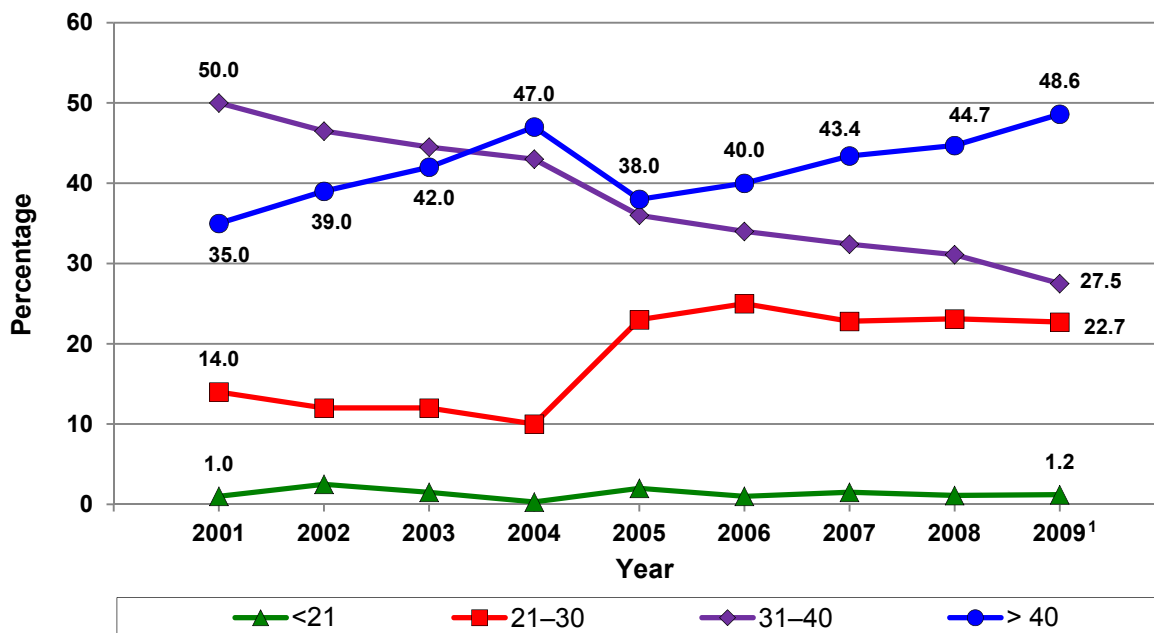
SOURCE: Wayne County Medical Examiner Office, as reported by Cynthia Arfken at the June 2010 CEWG meeting

11, and 1 percent for male adults, female adults, and juveniles, respectively. In addition, primary treatment admissions for cocaine constituted 3.9 percent of total treatment admissions in 2009, compared with 6.6 percent in 2008, and the percentage of seized drug items testing positive for cocaine was also at a near 10-year low, with 9.4 percent testing positive. In Honolulu, all cocaine indicators were reported as declining, with the exception of treatment admissions, which had increased slightly from 2008 to 2009, according to the area representative.

- Cocaine-related treatment admissions in Boston reflected a slight increase in the proportion of males (60 percent in 2009, an increase from 56 percent in 2008), with a corresponding slight decrease in females (from 44 percent in 2008 to 39 percent in 2009). Also in Boston, 2009 cocaine admissions showed a shift toward higher proportions of Latinos and continued lower percentages of African-Americans, according to the

area representative. In contrast, in Philadelphia and Atlanta, African-Americans constituted the majority of primary cocaine treatment admissions (at 67.2 percent of admissions in Philadelphia in 2009 and 71.9 percent of admissions in 2009 in Atlanta, an increase over 65.6 percent of admissions in 2008 for Atlanta). The Philadelphia area representative reported a gradual aging of the population of primary cocaine treatment admissions. Clients older than 40 represented 43.4 percent of cocaine admissions in 2007, 44.7 percent in 2008, and 48.6 percent in 2009 (figure 4). In Detroit, cocaine-related primary treatment admissions in 2009 were predominantly male (61 percent) and age 35 or older (87.2 percent). The St. Louis area representative reported that primary treatment admissions for cocaine were 65.7 percent male, and most were 35 or older (79.6 percent) in 2009. Elsewhere in the Midwest, qualitative data in Cincinnati indicated that new cocaine users were

**Figure 4. Percent of Primary Treatment Admissions for Cocaine, by Age Group, Philadelphia: 2001–2009**



<sup>1</sup>Among 85.5 percent of cocaine treatment admissions who reported a major route of administration of the drug, it was “smoked” in 2009.

SOURCE: Behavioral Health Special Initiative Client Data System, Philadelphia, uninsured clients only, as reported by Samuel Cutler at the June 2010 CEWG meeting

more likely to be young, some as young as 14. An increase in cocaine use among females was also reported by focus group participants in the Cincinnati area. In the State of Arizona during 2005–2009, American Indian cocaine-related hospital admissions were younger than Latino, White, and African-American cocaine admissions. Several CEWG area representatives continued to report cocaine contaminated with adulterants, particularly levamisole. Levamisole, used in veterinary medicine as an anti-parasitic drug, is no longer an approved drug for use in humans. (It was previously approved as a cancer medication.) Negative effects from levamisole include agranulocytosis, a relatively uncommon condition in the United States, and severe neutropenia.

- In Maine, the area representative reported that 38 percent of samples seized and identified by law enforcement in 2009 contained levamisole, compared with 18 percent of samples in 2008. In Philadelphia, 57.6 percent of deaths with the presence of cocaine also tested positive for levamisole.
- The area representative for Washington, DC, reported large percentages of cocaine contaminated with levamisole in the city. The Office of Chief Medical Examiner for the District of Columbia reported that up to 95 percent of cocaine-related cases contained levamisole. The area representative reported a continuing problem with adulterated cocaine in Miami, where it is estimated that the majority of kilograms imported into southern Florida are cut with levamisole that is most likely added at processing laboratories in Colombia.
- Sixty-seven percent of cocaine items seized and identified in the Cincinnati area in 2009 contained levamisole. The area representatives from Detroit and Minneapolis/St. Paul also reported that levamisole was detected in deaths in their areas involving cocaine. Figure 3 shows this increase for Detroit from 2007 to 2009. In Seattle, where cocaine indicators continued to be high, most cocaine also contained levamisole, according to the area representative.
- Several area representatives reported on the roles of supply, price, and purity of cocaine in their areas and their relationships to drug use and abuse. The discussion as to whether declining cocaine indicators across the country could be related to declining purity and availability, along with higher prices, continued.
  - In the Northeast region, cocaine was considered to be available throughout several CEWG areas. In New York City, street reports suggested that cocaine was highly available, but crack quality may have declined. The Boston area representative reported variable levels of purity.
  - Although cocaine was reported to be “widely available” in South Florida in 2009, the Miami area representative reported that the lower purity of the drug entering the United States may contribute to decreasing cocaine indicators in that area.
  - Ethnographic reports in Chicago, where cocaine indicators remained high and stable, suggested that the demand for powder cocaine on the streets was low and its quality had declined. Crack cocaine, however, remained highly available there, with moderate and unchanged quality, according to the area representative. In Cincinnati, the supply and quality of cocaine dropped on the street in 2008 and 2009 due to larger drug seizures by law enforcement. Qualitative data indicated that a high number of users reported that it was commonplace to “re-rock” crack cocaine after a purchase to remove as many impurities as possible. Subjective data suggested that cocaine dealers in that city were switching to selling heroin as a result.
  - The Texas area representative reported that while cocaine indicators were down in Texas, prices were up, and wholesale quantities had high purity levels. In Phoenix, where

all cocaine indicators were down, the area representative reported that a ban on shrimp fishing off the Sinaloa and Sonoran coasts of Mexico had possibly decreased cocaine supplies, since one method of smuggling cocaine into Arizona is in loads of frozen shrimp. A September 2009 lift of the ban may result in future increases in cocaine shipments. From January 2007 to September 2009, the price per pure gram of cocaine increased in San Diego (where indicators were down) by 75.4 percent (from \$99.24 to \$174.03), and the purity decreased by 31.5 percent (from 67 to 46 percent pure). The San Francisco area representative reported substantially higher wholesale cocaine prices in 2009, when compared with 2007. Wholesale prices for cocaine in Los Angeles, however, were down slightly from previous years.

- Smoking remained the preferred route of administration for cocaine across all CEWG areas. In Detroit, 96.2 percent of clients entering treatment for cocaine smoked the drug, as did 88.8 percent in St. Louis. Only Maine had fewer than 50 percent of cocaine-related treatment admissions reporting smoking as the primary route of administration (at 48.3 percent).
- Treatment admissions data for 2009 revealed that treatment admissions for primary cocaine/crack, as a percentage of total drug treatment admissions, including primary alcohol admissions, ranked first in frequency in none of the 22 reporting CEWG areas, although it ranked second in Miami/Dade County and San Francisco (table 3). The most common route of administration in all reporting areas was smoking (section III, table 5). The largest decreases in primary cocaine admissions, excluding primary alcohol admissions, between 2008 and 2009 were observed in Seattle and Minneapolis/St. Paul (of 14 reporting CEWG areas), at approximately 8 percentage points each (section III, table 7). Over the 5-year period from 2005 through 2009, declines were noted in 12 of 14 areas reporting data. Atlanta, Minneapolis/St. Paul, and St. Louis saw the largest declines in cocaine admissions, at 19.5, 13.3, and 12.4 percentage points, respectively, over the period (section III, table 7).
- Cocaine was the drug most frequently identified by forensic laboratories in 7 of 22 reporting CEWG areas. Based on forensic laboratory analysis of drug items identified in 2009, cocaine/crack ranked first in three of five areas in the southern region (Miami, Atlanta, and Washington, DC); three of four areas in the northeastern region (Boston, New York City, and Maine); and one of eight areas in the western region (Denver). Cocaine ranked first in none of the five CEWG areas in the midwestern region in frequency of drug items identified. Cocaine ranked second in drug items identified in 2009 in 11 of 22 CEWG areas (table 2). The proportion of cocaine items identified in NFLIS laboratories in 2009 ranged from 9.4 percent in San Diego to 61.8 percent in Miami (figure 22; appendix table 2).

## Heroin

- *Heroin indicators remained high in many CEWG areas, particularly those in the Northeast and Midwest. A concern over the increase in heroin indicators, documented in recent CEWG meeting reports, continued into this reporting period. Nine area representatives from all four CEWG regions of the country reported increases in heroin indicators: Baltimore/Maryland/Washington, DC, and Miami/Dade County in the South; Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis in the Midwest; and Los Angeles and Phoenix in the West. Several other area representatives reported mixed and stable indicators, including Boston, Maine, New York City, and Philadelphia in the northeastern region; Atlanta in the southern region; and Denver, San Diego, Seattle, and Texas in the western region. Only Honolulu and San Francisco reported declines in all heroin indicators.*
- In the Northeast, high levels for heroin indicators were reported in Boston, New York City, and Philadelphia. Only the Maine area

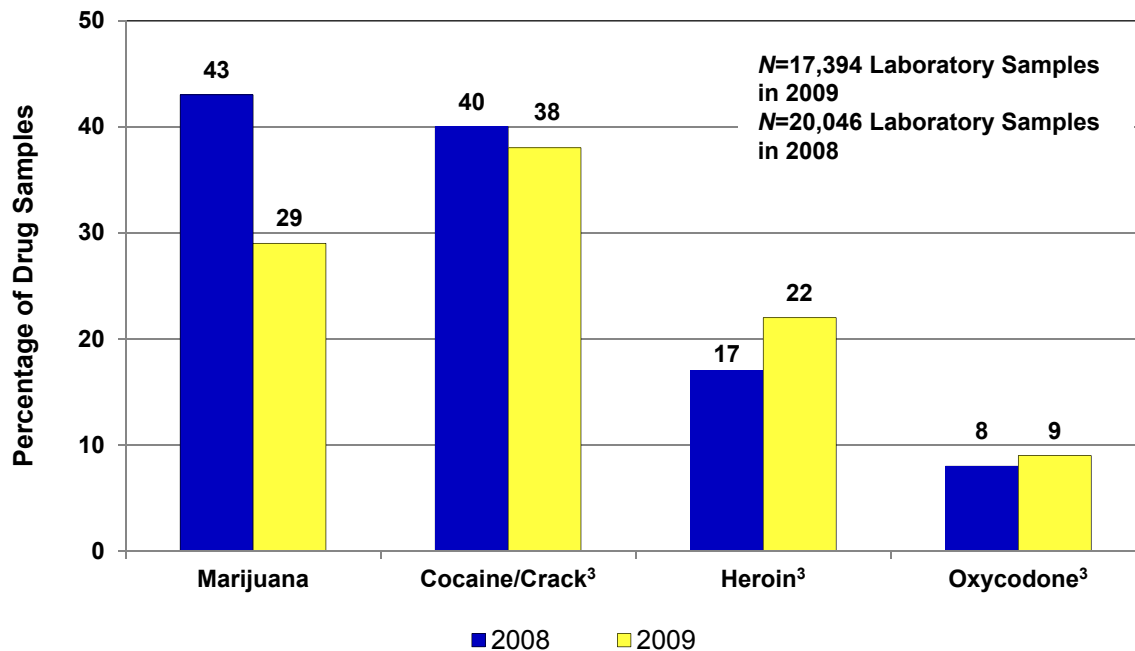
representative reported moderate and potentially slightly decreasing indicators.

- The area representative from Boston reported an increase in heroin-related primary treatment admissions and NFLIS drug items seized and identified, with stable measures for helpline calls and drug arrests. Thus, proportions of primary treatment admissions for heroin increased to the highest level in 10 years of reported data in 2009 (51 percent), up from 49 percent in 2008, while NFLIS drug items identified in the Boston MSA increased from 17 to 22 percent from 2008 to 2009 (figure 5). (According to the Boston area representative, total drug items identified, excluding those identified

as containing cannabis/marijuana, were used to compute these NFLIS percentages for drugs other than marijuana/cannabis due to recent changes in local marijuana laws; percentages for marijuana/cannabis were computed based on total drugs identified.)

- In New York City, heroin was still seen as a major problem, although indicators were mixed. The area representative, however, reported a concerning increase in some heroin indicators in the suburban area surrounding New York City. Street researchers have reported an increase in the number of young White buyers from suburban New York and New Jersey at “copping areas” in New York City.

**Figure 5. Percentage<sup>1</sup> of Drug Items Identified as Heroin and Selected Other Drugs Among NFLIS Laboratory Samples, Boston MSA<sup>2</sup>: 2008 and 2009**



<sup>1</sup>Percentages for cocaine/crack, heroin, oxycodone are based on “adjusted” totals of laboratory samples excluding marijuana samples, while all drug items identified were used to compute marijuana percentages. This was done because of the marijuana law change, which contributed to 4,418 fewer marijuana samples in 2009, compared with 2008.

<sup>2</sup>Boston MSA includes seven counties: Essex, Middlesex, Norfolk, Plymouth, and Suffolk Counties in Massachusetts, and Rockingham and Strafford Counties in New Hampshire.

<sup>3</sup>Statistically significant changes were found in adjusted proportions of nonmarijuana NFLIS samples based on *t*-tests for two proportions, as reported by the Boston area representative.

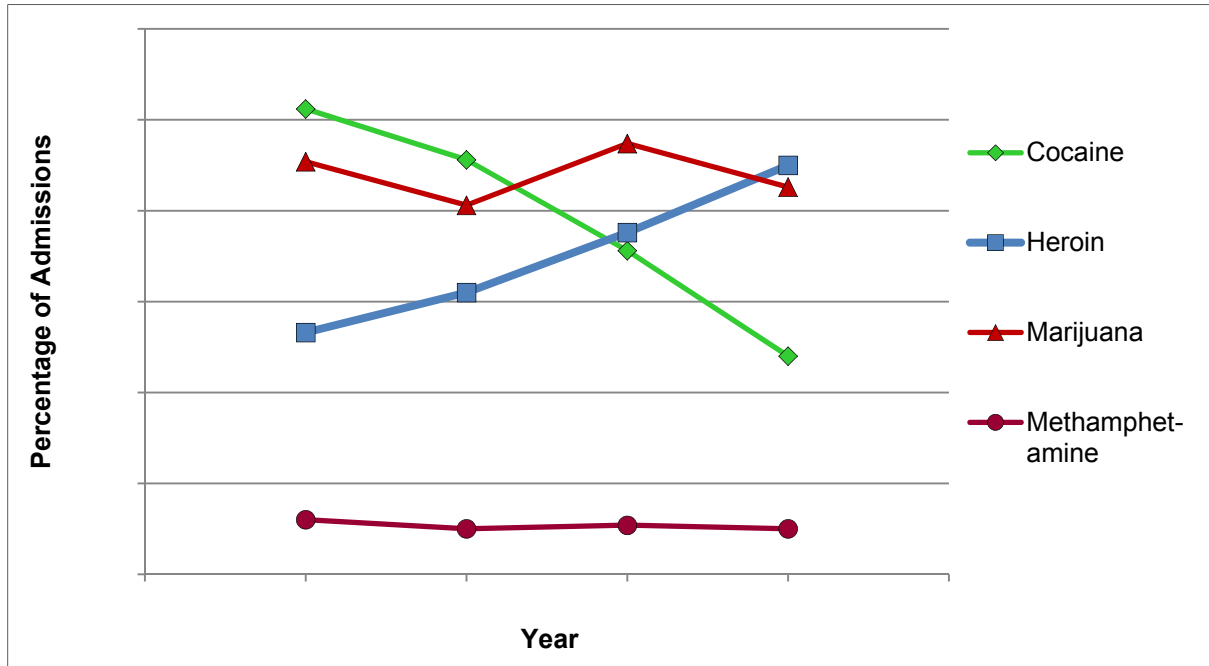
SOURCE: NFLIS, DEA; analysis by the Boston Public Health Commission Research and Evaluation Office, as reported by Daniel Dooley at the June 2010 CEWG meeting



- Heroin indicators remained low relative to other drugs in Atlanta and South Florida in the southern region, with mostly stable levels reported. However, the area representative from the Baltimore/Maryland/Washington, DC, area reported an increase in two key heroin indicators in Maryland—drug intoxication deaths and YRBS prevalence data for youth in 2009 compared with 2007.
- Most CEWG areas represented in the midwestern region reported high and increasing heroin indicators. The exception was Detroit, where proportions of heroin treatment admissions were reported as stable by the area representative in 2009 (at 32.3 percent of all publicly funded admissions, compared with 34.2 percent in 2008). Heroin continued to lead all other drugs in proportions of treatment admissions in Detroit.
- The representatives from Cincinnati, Minneapolis/St. Paul, and St. Louis reported increases in heroin indicators in their areas.
  - All indicators for heroin increased in 2009 in Cincinnati. Poison control data for the city showed a 52-percent increase in reported human heroin exposure cases in 2009 over 2008, and the Medical Examiner's Office recorded a 28-percent increase in deaths attributed to heroin in 2009 from the previous year.
  - Heroin indicators continued their substantial upward trends in the Minneapolis/St. Paul area. According to the area representative, treatment admissions for heroin and other opiates combined have more than doubled since 2002 in the Twin Cities, and they increased by 35.7 percent from 2008 to 2009. Arrests and seizures of Mexican heroin increased both in the Twin Cities area and throughout the State of Minnesota. During 2008, the Minnesota Drug Task Forces made 50 arrests for heroin. In 2009 and the first quarter of 2010, 125 arrests were made statewide, an increase of 150 percent. In 2008, the Minnesota Drug Task Forces seized 371 grams of heroin. In 2009 and the first quarter of 2010, 800 grams were seized, an increase of 116 percent.
  - The area representative from St. Louis reported that heroin availability was a problem of immediate concern in that area and that heroin activity was a new and persistent trend in both the urban and rural areas. Along with increases in both availability and purity, heroin-related treatment admissions and deaths attributed to heroin increased in the St. Louis area in 2009. In 2009, heroin was identified in 180 deaths in St. Louis City and County. In 2008, heroin was present in 137 deaths; in 2007 heroin was present in 65 deaths; and in 2006, there were 47 heroin-related deaths in St. Louis. Treatment admissions related to heroin constituted 22.5 percent of all admissions in the St. Louis area in 2009, an increase from 18.8 percent in 2008 (figure 6).
- In CEWG areas in the West, several CEWG area representatives reported high and increasing heroin indicators.
  - Although indicator levels in Denver were still relatively low compared with other drugs, such as marijuana or cocaine, several heroin indicators increased there in 2009, according to the area representative. For example, from 2008 to 2009, the proportion of heroin treatment admissions increased from 7.1 to 9.5 percent statewide and from 10.1 to 13.1 percent in the Denver metropolitan area.
  - The Los Angeles area representative reported heroin indicator levels as slightly increasing (treatment admissions, drugs seized and identified as heroin by NFLIS laboratories, and prevalence measures from the YRBS youth survey), while remaining at low to moderate levels across indicators.
  - Most heroin indicators continued to increase in Phoenix, according to that area representative (figure 7). Primary heroin treatment

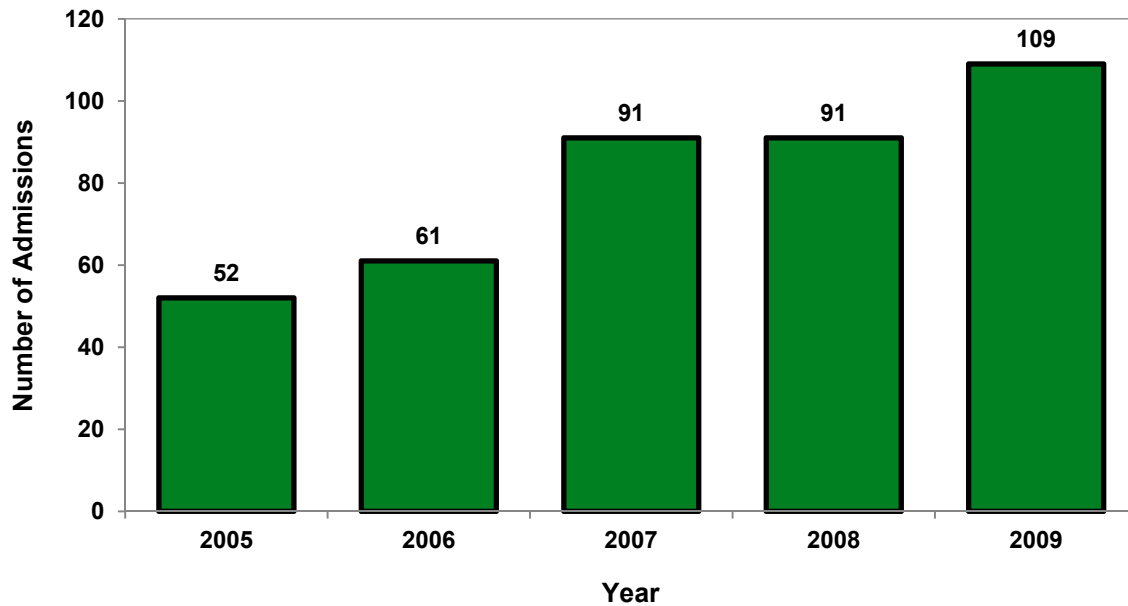


**Figure 6. Percentage of Primary Treatment Admissions for Heroin and Selected Other Drugs, St. Louis: 2006–2009**



SOURCE: TEDS, St. Louis, as reported by Heidi Israel at the June 2010 CEWG meeting

**Figure 7. Number of Heroin-Related Hospital Admissions<sup>1</sup>, Maricopa County (Phoenix Area): 2005–2009**



<sup>1</sup>The number of heroin-related hospital admissions was retrieved using a selected subset of diagnostic codes. Data may indicate direction of change over time, but they do not indicate the total volume of heroin-related admissions that actually occurred. SOURCE: Arizona Hospital Discharge System, Arizona Department of Health Services, analyzed by the University of Arizona Department of Family and Community Medicine, as reported by James Cunningham at the June 2010 CEWG meeting

admissions increased from 10 percent in 2007, to 14 percent in 2008, and to 17 percent in 2009. The number of drugs seized and identified as heroin by NFLIS laboratories also increased, from 421 in 2008 to 561 in 2009, as did numbers of heroin-related hospital admissions in Maricopa County from 2005 to 2009.

- The proportions of primary treatment admissions attributed to heroin/morphine were also up slightly in San Diego, from 17 percent in 2006 to 19.4 percent in 2009. Drug overdose deaths involving heroin/morphine also increased notably in San Diego to 113, the highest number of heroin/morphine deaths since 2003.
  - While heroin indicator levels continued to be high in San Francisco, the area representative reported declines in most indicators there. In Seattle, heroin persisted as a problem in indicator data, according to the area representative, but heroin-related overdose deaths involving heroin continued to decline and were down slightly in 2009, compared with 2008 (from 59 deaths in 2008 to 49 in 2009). The area representative from Honolulu reported low and stable heroin indicators.
- Based on qualitative data, the area representative from Miami reported an emerging pattern of concurrent use of heroin and prescription opioids, as well as a concern that a crackdown on the availability of prescription opioids for abuse may cause users to turn to heroin in greater numbers. The Denver area epidemiology work group reported that some Denver street outreach workers were continuing to see an increased number of heroin users. They reported many were suburban White males who were abusing prescription narcotics but found smoking heroin to be less expensive. These new young users refer to “smoking black tar opium” and sometimes are unaware that what they are calling “opium” is heroin. These users feel that calling heroin opium is more socially acceptable, and only a small number of these users are “graduating” to injecting. The Seattle area representative reported that a 2009 syringe exchange survey in King County revealed that a substantial minority of heroin users (39 percent) reported that they were “hooked on prescription-type opiates” before they began using heroin.
- Several area representatives noted that heroin seemed to be moving into suburban and rural communities. The Chicago area representative noted an increase in deaths due to heroin overdoses in the suburban counties surrounding the urban area. Similarly, deaths in rural counties around St. Louis related to heroin continued to increase, according to that area representative.
- Some CEWG representatives reported shifts in the age of heroin users in their areas. An increase in young users, first reported by CEWG representatives in June 2009, continued in several areas.
  - In the Northeast, heroin admissions in Boston were younger; clients age 18–25 increased from 21 percent of all heroin-related primary admissions in 2008 to 24 percent in 2009, according to the area representative.
  - In the Midwest, the Chicago area representative reported that, according to the 2009 YRBS survey, the proportions of Chicago high school students reporting ever having used heroin were the highest ever measured by the survey, at 4.7 percent (CI=3.0–7.2); this increase was statistically significant when comparing 2005 (2.0; CI=0.9–4.4) with 2009 self-reported heroin use. Approximately 28.3 percent of heroin admissions in 2009 in St. Louis were age 25 or younger (69.4 percent were younger than 35), stable from the previous year’s proportions.
  - Some CEWG areas in the western region also showed increases in younger heroin treatment admissions. The Los Angeles area representative reported an increase in 2009 in treatment admissions among clients age 18–34. In Colorado, the proportion of younger heroin clients entering treatment

statewide has been on the rise, according to the Denver area representative. Proportions of heroin clients younger than 25 increased from 14.6 percent in 2007, to 18.2 percent in 2008, to 22.5 percent in 2009. The area representative from San Diego reported a similar increase in younger heroin treatment admissions. Treatment admissions younger than 34 constituted 55 percent of all San Diego heroin-related admissions in 2009; admissions of clients age 18–25 increased from 18 percent in 2005 to 26 percent in 2009. Young adult treatment admissions for heroin have increased in Seattle over the past decade. In 2009, 29 percent of primary heroin treatment admissions were between ages 18 and 29, compared with 1999, when this age group constituted 17 percent of heroin-related primary treatment admissions. In Texas, the area representative reported increases in heroin indicators for a younger population. This was first noticed in previous years with the “cheese heroin” (a mixture of Tylenol PM® and heroin) situation in Dallas. Cheese heroin continued to be reported as a problem in Dallas, but heroin treatment admissions among teenagers and young adults also increased statewide in 2009. In Texas, heroin treatment admissions among clients age 20–29 increased from 35 percent in 2005 to 41 percent in 2009.

- Although the majority of primary heroin-related treatment admissions across all areas continued to be male, an increase in female admissions for heroin was reported in Boston, Philadelphia, and Denver. Texas experienced a shift in ethnicity among heroin clients. There, the proportion of all treatment clients with a primary problem with heroin who were Hispanic increased from 23 percent in 1996 to 56 and 54 percent in 2008 and 2009, respectively.
- Injection continued to be the preferred route of administration for heroin-related treatment admissions in most CEWG areas, but other routes of administration were gaining in popularity.
  - In Boston, 84 percent of all heroin admissions injected the drug, up from 80 percent in 2008 and 67 percent in 2000 (figure 8). Injectors increased in New York City to 40 percent among primary treatment admissions for the first time since 1997, up slightly from 39 percent in 2008. However, 58 percent of heroin-related treatment admissions in New York City used the drug intranasally.
  - The Chicago area representative reported that injection as a preferred route of heroin administration among treatment admissions was low there, while “snorting” (inhaling) continued as the primary route of administration for heroin for clients entering treatment (at 82 percent). In Detroit, the major route of administration reported for heroin-related treatment admissions varied by client ethnicity. Only 34.7 percent of African-American primary heroin treatment admissions in Detroit injected heroin, while 74.2 percent of White admissions and 88.9 percent of Latino admissions injected the drug. In St. Louis, 51 percent of heroin treatment admissions injected the drug, while 49 percent reported smoking or snorting the drug.
  - In Denver, where injecting has been the preferred route of administration for heroin, the proportion of heroin treatment admissions injecting declined from 88.2 percent in 2001 to 78.0 percent in 2009. The proportion of admissions who smoked heroin has been gradually increasing—from 9.5 percent in 2007, to 11.9 percent in 2008, to a new high of 14.9 percent in 2009.
  - The Texas area representative reported that while most heroin clients entering treatment injected the drug, the proportion inhaling heroin increased from 4 percent of all heroin admissions in 1996 to 19 percent in 2009. During that time, the proportion of admissions who reported inhaling as the major route of administration who were also Hispanic increased from 26 to 61 percent, and the average age of inhalers decreased

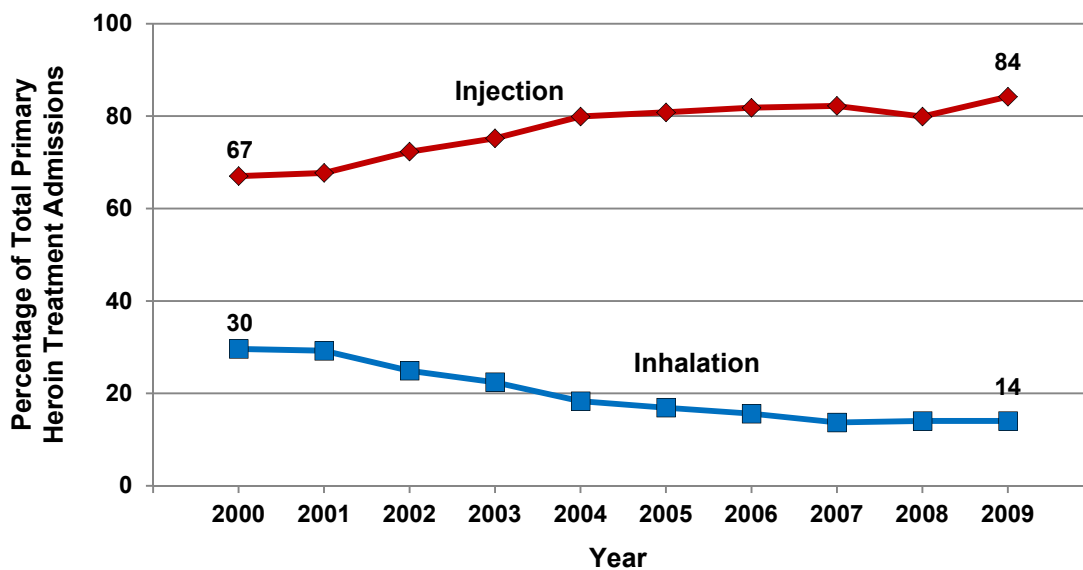
from 30 to 28 years among heroin treatment admissions in that State.

- South American and Mexican heroin (Mexican black tar or brown) continued to dominate the heroin market in the United States. The St. Louis area representative reported on the popularity of “concrete” heroin, named for its gray color, which is widely available and snortable in that area. It is distributed through Chicago by Mexican drug gangs who get much of it from Colombia. The San Diego area representative presented anecdotal reports of the use of white heroin (called “China White,” “blanca,” or “panda”) by injection drug users in Tijuana. Users report that the heroin gives them a “better high” than black tar heroin, but results in worse withdrawal symptoms and carries a higher risk of overdose. Users have also reported allergic reactions when using this white heroin. The Phoenix CEWG area representative reported that white heroin was being trafficked through Phoenix, but there was no indication that it was being sold there.

The Texas representative reported that wholesale quantities of Colombian heroin were appearing in 2009 in Texas, along with the traditional black tar. In addition, there have been anecdotal reports of Southwest Asian heroin being brought back into Texas by troops returning from Afghanistan, according to the Texas area representative.

- Heroin purity and price varied by area. A few examples of reports of heroin price and purity follow. Others are contained in Volume II full area reports. In New York City, the average purity of heroin decreased, as did the price per milligram pure in 2008. According to the DEA Domestic Monitor Program, the purity of heroin in New York City fell slightly to 47.1 percent in 2008. From 1992 to 2000, the purity was generally greater than 60 percent, but since 2004, it has remained below 50 percent. The price per milligram pure also fell from \$0.79 in 2007 to \$0.66 in 2008. However, in Philadelphia, the street-level purity, at 55 percent in 2008, continued to be among the highest in the Nation, while

**Figure 8. Major Route of Administration Reported by Primary Heroin Admissions in Substance Abuse Treatment, by Percentage, Greater Boston<sup>1</sup>: 2000–2009<sup>2</sup>**



<sup>1</sup>Greater Boston includes Boston, Brookline, Chelsea, Revere, and Winthrop Community Health Network Area (CHNA) 19.

<sup>2</sup>N=10,025 treatment admissions with heroin as the primary drug of abuse in 2009.

SOURCE: Massachusetts Bureau of Substance Abuse Services, Massachusetts Department of Public Health, analyzed by Boston Public Health Commission Research and Evaluation Office, and reported by Daniel Dooley at the June 2010 CEWG meeting

the price per milligram pure has been stable, at \$0.71. Heroin purity continued to increase in Chicago and reached the highest level of the decade in 2008. Finally, a focus group of law enforcement officials in Detroit reported that heroin was relatively inexpensive in the city, and the drug continued to be associated with property crime.

- Heroin primary treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore<sup>7</sup> (approximately 53 percent) and Boston (51.0 percent) in 2009. In Boston, Baltimore, and Detroit, heroin was the substance most frequently reported as the primary problem at treatment admission in the reporting period. It ranked second in three areas, namely Maryland, New York City, and St. Louis (table 3).
- Injection of heroin was the main mode of administration of the drug reported among primary heroin treatment admissions in 2009 in most areas, with the exception of Baltimore, Detroit, and New York City, where inhalation was more commonly reported as the major route of administration (section III, table 9).
- The largest increases in the proportion of primary heroin treatment admissions, excluding primary alcohol admissions, from 2008 to 2009 among the 11 of 14 reporting areas experiencing increase were seen in St. Louis, Phoenix, and Denver, where proportions of heroin admissions increased by 6.7, 4.6, and 3.1 percentage points, respectively. In three areas, Baltimore, Hawaii, and New York City, proportions of primary heroin admissions declined by approximately 1 percentage point or less in the 2-year period. In the 5 years between 2005 and 2009, when 8 of 14 reporting areas showed increases in proportions of primary heroin treatment admissions, St. Louis and Phoenix had the largest increases, at 19.1 and 10.7 percentage points, respectively. Declines in heroin admissions as a percentage of all admissions excluding primary alcohol admissions were observed in five areas, with the

largest declines in Seattle, Maine, and New York City (5.1, 4.9, and 4.2 percentage points, respectively). No change was noted over the period in heroin admissions in Los Angeles. (section III, table 11).

- In one-half (11) of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in 2009, compared with 17 of 22 areas in 2008. Proportions were highest in Baltimore and Maryland (approximately 22 and 20 percent, respectively). They were lowest in Honolulu and Atlanta, at approximately 1–2 percent of drug items identified in each area (figure 22; section III, figure 24; appendix table 2). Heroin was not ranked first in drug items seized in any CEWG area, although it appeared in second rank in Maine in 2009 (table 2).

### Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

- *Indicators for opiates/opioids other than heroin continued to increase across most CEWG areas. The primary prescription opioids appearing in the indicator data across all areas continued to be oxycodone and hydrocodone, although buprenorphine was reported to be gaining in popularity by several CEWG area representatives.*
- All of the area representatives in the northeastern region reported increases in indicators for opiates other than heroin and prescription opioids in their areas.
  - In Boston, other opiate indicators remained at moderate levels but were increasing, according to the area representative. Although the proportion of primary treatment admissions for other opiates/synthetics remained between 3 and 4 percent for 8 years from 2002 to 2009, the 859 opiate admissions in 2009 was the highest number in 10 years of reported data in Boston. Additionally, 5 percent of Boston

<sup>7</sup>Treatment data for Baltimore are for the MSA.



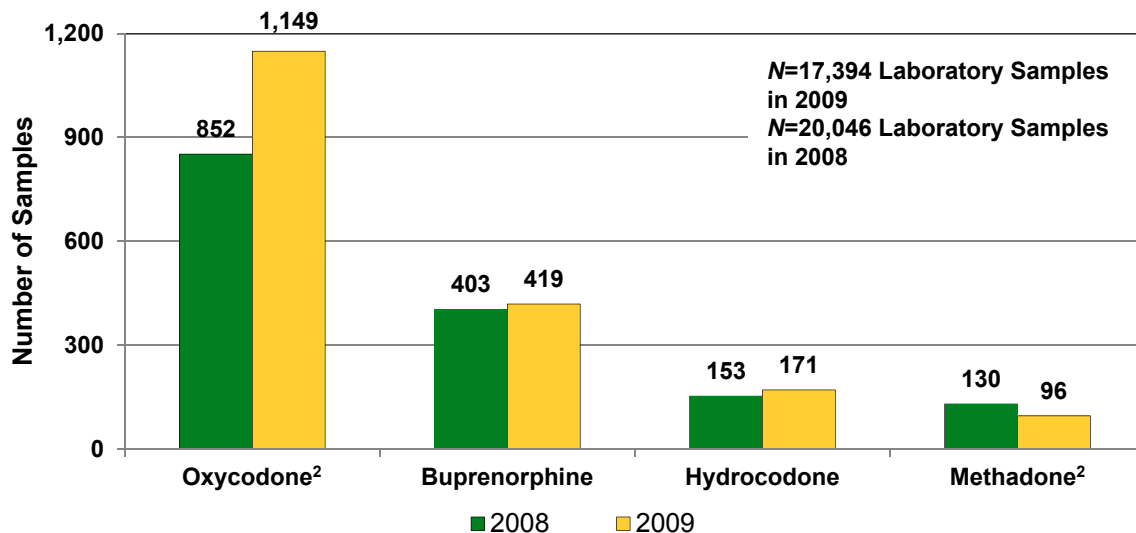
treatment admissions cited other opiates/synthetics as secondary drugs of abuse, up from 2 percent in 2008. Calls to the drug helpline in Boston with nonheroin opiate/opioid mentions also increased, from 17 percent in 2007 and 2008 to 20 percent in 2009. The number of drugs seized and identified as oxycodone and hydrocodone in the Boston MSA by NFLIS laboratories also increased; for example, the amount of oxycodone drug items identified increased by 35 percent from 2008 to 2009 (figure 9).

- The Maine area representative reported continuing high and increasing levels of prescription opioids. Those indicators included increased deaths related to oxycodone (figure 10) and increases in narcotic analgesic-involved arrests, treatment admissions, and drugs seized and identified as opiates/opioids for the State. Maine impaired driver urinalysis data for 2010 (through May 2010)

showed opiates far ahead of other drugs tested (excluding alcohol), at 35 percent, up from 28 percent in CY 2009.

- Although relatively low levels of opiates and prescription opioid indicators were reported in New York City, they continued to increase. Increasing other opiate use and consequence indicators were reported by the area representative in the suburban area surrounding New York City.
- Both primary and secondary treatment admissions for other opioids increased in Philadelphia in 2009. They increased from 136 in 2008 to 513 in 2009, according to the area representative. Oxycodone was the most prevalent prescription opioid in Philadelphia indicators, including deaths and treatment admissions.
- In CEWG areas in the southern region, indicators reflecting consequences associated with

**Figure 9. Number of Opioid Drug Samples Identified in Forensic Laboratories in the NFLIS System, Boston MSA<sup>1</sup>: 2008 and 2009**



<sup>1</sup>Boston MSA includes seven counties: Essex, Middlesex, Norfolk, Plymouth, and Suffolk Counties in Massachusetts, and Rockingham and Strafford Counties in New Hampshire

<sup>2</sup>Statistically significant proportional changes from 2008 to 2009 in adjusted proportions of nonmarijuana NFLIS samples based on *t*-tests for two proportions, as reported by the Boston area representative (proportions of oxycodone samples increased from 7.5 to 8.7 percent of nonmarijuana samples, while methadone samples decreased from 1.1 to 0.7 percent of nonmarijuana samples).

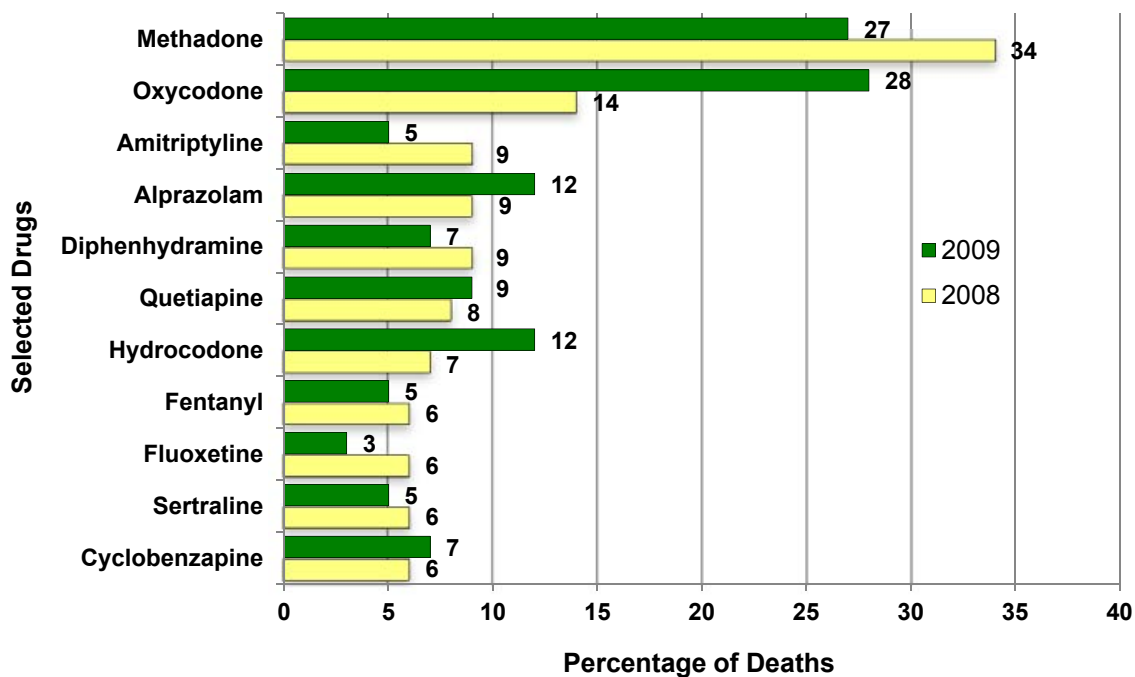
SOURCE: NFLIS, DEA, received 5/10/2010; analysis by the Boston Public Health Commission Research and Evaluation Office, as reported by Daniel Dooley at the June 2010 CEWG meeting

prescription opioids continued to be very high and stable in the South Florida area, particularly in Broward County. Prescription opioids accounted for most opiate-involved DAWN *Live!* ED reports and deaths in Broward County. In 2009, 5,275 individuals died in Florida with 1 or more prescription drug in their systems; 47 percent of the deaths ( $n=2,488$ ) had at least 1 prescription medication that was considered to be a cause of death. By comparison, in 2008, 4,924 individuals died in Florida with 1 or more prescription drugs in their systems. Oxycodone continued to be the most frequently reported opioid involved in nonmedical use in the South Florida area and across Florida. While indicators of prescription opioids remained at a low level in the Atlanta area, the area representative reported an increase in treatment admissions, deaths, and drugs seized and identified by NFLIS related to oxycodone and hydrocodone in 2009, compared with 2008. Treatment admissions for oxycodone

represented a small percentage of overall admissions in Atlanta, but they more than doubled from 2008 to 2009. Most indicators for opiates and prescription opioids were stable from previous years in the Baltimore/Maryland/Washington, DC, area, but oxycodone intoxication deaths increased from 81 in 2008 to 97 in 2009 in Maryland. By contrast, methadone deaths decreased statewide but increased in the city of Baltimore over the period. The number of oxycodone intoxication deaths in Baltimore City tripled, from 7 in 2008 to 21 in 2009.

- Area representatives in the midwestern region reported moderate or high levels for opiates other than heroin and prescription opioids indicators. All reported increasing indicators except Cincinnati, where indicators decreased slightly. In Cincinnati, poison control center data showed the number of hydrocodone combination narcotic exposures in 2009 totaled 321, representing a nearly 24-percent decrease from 2008. The

**Figure 10. Percentage of Deaths Caused by Selected Prescription Opiates/Opioids and Other Drugs, Maine: 2008 and 2009**



SOURCE: Office of the Medical Examiner, Maine, as reported by Marcella Sorg at the June 2010 CEWG meeting



number of intentional methadone cases recorded in poison control data during 2009 was 64, a decrease of 7 percent from the previous year. Additionally, the Hamilton County Coroner's Office recorded 94 deaths during 2009 that had evidence of opiate/opioid use on the part of the decedent, representing a drop of nearly 8 percent from the previous year. Opiate/opioid levels continued to be moderate in both Chicago and Detroit relative to other drugs, but other opiate indicators were increasing, according to the area representatives from those cities. Hydrocodone indicators were higher than those for oxycodone in Chicago, Detroit, and Cincinnati. Although reporting slightly decreasing indicators, the area representative from Cincinnati noted continuing concerns in that area regarding the abuse of prescription opioids. Similarly, the area representative from the Minneapolis/St. Paul Twin Cities area cited the substantial upward trend in other opiates/opioids in area indicators as a serious concern. Opiates other than heroin, primarily prescription narcotics, accounted for 8.3 percent of total treatment admissions in the Twin Cities in 2009, compared with 6.2 percent in 2008 and only 1.4 percent in 2000. A record-high number of 1,722 treatment clients reported other opiates as their primary substance abuse problem in 2009, a fourfold increase since 2002. In St. Louis, rural police noted that narcotic analgesics were a major issue, according to the area representative.

- Reports from CEWG area representatives in the western region showed stable or increasing indicators for opiates other than heroin and prescription opioids.
  - Indicators for other opiates and prescription opioids were up in Denver, Los Angeles, Phoenix, San Francisco, and Seattle. Both statewide in Colorado and in the Denver area, other opioid treatment admissions increased from 2001 through 2009. Likewise, the rate of other opioid hospital discharges in Denver has steadily increased, along with the proportion of other opioids among Denver drug mortality cases. Oxycodone accounted for

4.1 percent of Denver drug-related deaths in 2006; such deaths increased to 23.2 percent by 2009. Increases in the number and rate of oxycodone prescriptions filled in Denver from 2007 to 2009 are shown in figure 11. In Los Angeles, hydrocodone was the most frequent prescription opioid identified by NFLIS laboratories in 2009, as in 2008. Narcotics other than heroin were reported in 32 percent of Los Angeles County coroner toxicology cases in 2009, a 25-percent increase over 2008. The San Francisco area representative reported an increase in indicators for hydrocodone and oxycodone in 2009, although from a low level. In Seattle, primary treatment admissions for pharmaceutical opioid use continued to increase, particularly among clients age 18–29. Drug-caused deaths involving pharmaceutical opioids continued a multiyear increase in Seattle in 2009 (from 29 in 1999 to 127 in 2005, and 160 in 2009), and the area representative reported that they were the most common substance identified in deaths in that area.

- The area representatives for Honolulu and San Diego reported stable indicators for other opiates and prescription opioids. In San Diego, primary treatment admissions for oxycodone exceeded those for other narcotic analgesics (of the 553 primary treatment admissions for prescription opiates, 324 were for oxycodone in 2009), but hydrocodone was more commonly detected in drugs seized and identified in the State and local San Diego area (appendix table 2.18).
- The area representative from Texas, where indicators for other opiates and prescription opioids were reported as mixed, noted qualitative evidence that codeine cough syrup continued to be abused in the State and that a codeine “promethazine cocktail” was gaining in popularity. Other areas showing increases in codeine abuse included Philadelphia, Detroit, and Los Angeles, where

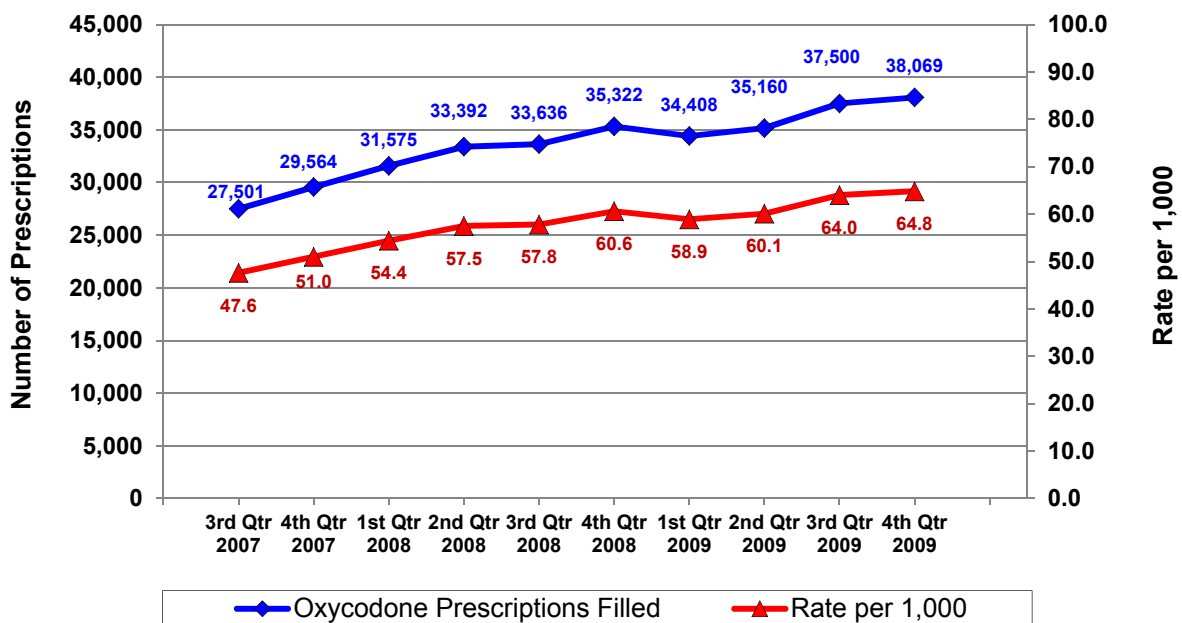
codeine ranked among the NFLIS top 10 drugs seized and identified in those areas (as it had in 2008), and in San Diego, where the area representative reported an increase in drug overdose deaths related to codeine between 2008 and 2009.

- Several area representatives reported continuing increases in buprenorphine indicators. In Cincinnati, prescriptions for buprenorphine continued to increase. According to the area representative from Cincinnati, poison control calls involving buprenorphine in the State of Ohio increased by 326 percent from 2007 to 2009 (a majority of those calls concerned children age 3 and younger). Additionally, prescriptions filled per 100,000 residents in Ohio increased by 296 percent from 2007 to 2009 (figure 12). Some representatives reported anecdotal evidence that although indicators were increasing for buprenorphine, many users were turning to it

to avoid withdrawal, moderate their addiction to heroin, or to “get healthy.”

- Although methadone continued to appear in indicators across all CEWG areas, decreases in deaths were noted in some areas. In Maine, deaths attributed to methadone continued a downward trend in 2009 that began in 2005. In Maryland, methadone intoxication deaths decreased by 21 percent, from 164 in 2008 to 129 in 2009. Deaths in 2009 involving methadone were also down in San Diego and Texas, according to those area representatives.
- Fentanyl indicators continued their downward trend in most CEWG areas. However, deaths involving fentanyl increased in the Denver and San Diego areas in 2009 compared with 2008. The Texas area representative reported an increase in poison control cases of abuse and misuse of fentanyl, from 31 cases in 2008 to 143 cases in 2009.

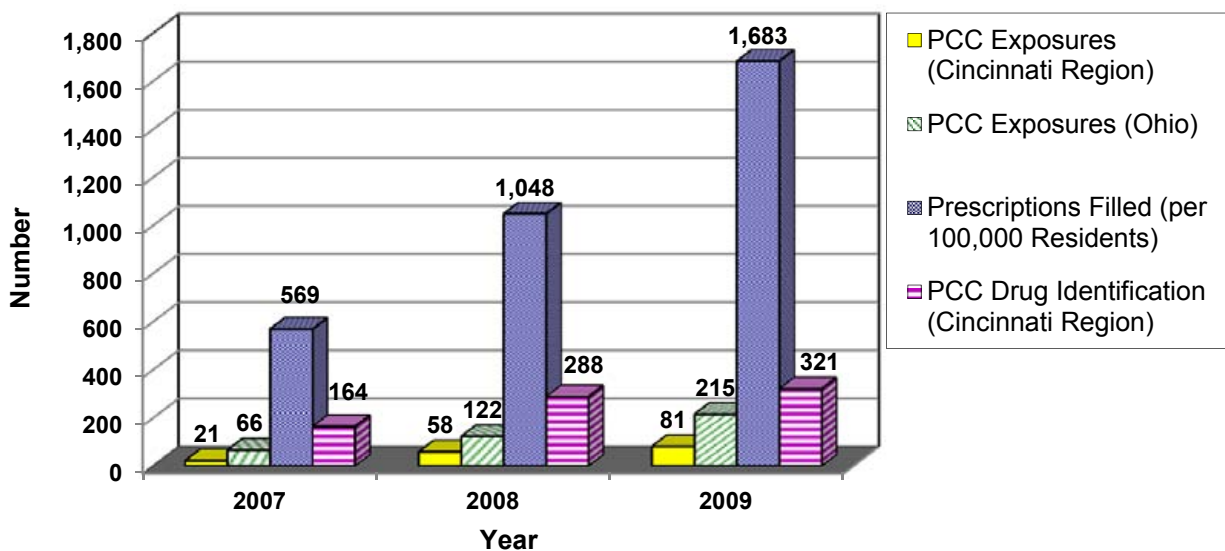
**Figure 11. Number of Oxycodone Prescriptions Filled and Rate per 1,000 From the Prescription Drug Monitoring Program (PDMP), Denver: Quarterly from Third Quarter 2007 Through Fourth Quarter 2009**



SOURCE: Prescription Drug Monitoring Program (PDMP), Colorado Department of Regulatory Agencies, Division of Registrations, Board of Pharmacy, as reported by Kristen Dixon at the June 2010 CEWG meeting

- The majority of treatment clients whose primary drug of abuse was opiates other than heroin and/or prescription opioids continued to be White, male, and young adults in their twenties or thirties. However, treatment admissions for other opiates in Texas continued to be predominantly female in 2009, at 57 percent. In Detroit, females represented 62 percent of primary treatment admissions for opiates and opioids, an increase over 57.7 percent in 2008. Similarly, the proportion of female treatment admissions for opiates and opioids increased in Baltimore in 2009 over 2008, from 56 to 59.4 percent. The Boston area representative reported that in 2009, female other opiates/synthetics treatment clients reached their highest level (39 percent) in 10 years of reported data.
- The relationship between nonmedical use of prescription opioids and heroin use continued to be a topic of concern. Data from a survey conducted in May 2009 among syringe exchange program users in King County (the Seattle area) showed that a substantial minority of heroin users were “hooked on prescription-type opiates” before they began using heroin. The Miami area representative reported continuing concurrent and sequential use of heroin and prescription opioids, rather than a progression from or to heroin. In 2008, 45 percent of heroin-related deaths in Florida also had at least one prescription opioid detected, and the area representative reported a concern for the potential escalation of injecting drug use in that region.
- While none of the 19 CEWG areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, other opiates ranked second in Maine and third in Minneapolis/St. Paul (table 3). Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from 1.5 to 9.1 percent in 18 of 19 reporting CEWG areas in 2009. The outlier was Maine, where nearly

**Figure 12. Number of Poison Control Center (PCC) Buprenorphine Exposures in Cincinnati and Ohio, Compared With Number of Buprenorphine Prescriptions Filled per 100,000 Residents and Drug Identification in the Cincinnati Region: 2007–2009**



NOTE: PCC exposures in Ohio increased by 326 percent from 2007 to 2009, while prescriptions filled per 100,000 residents increased by 296 percent in the same period

SOURCES: Ohio Poison Centers unconfirmed data; Ohio State Board of Pharmacy; and Cincinnati Drug and Poison Information Center, as reported by Jan Scaglione at the June 2010 CEWG meeting

29 percent of primary treatment admissions were for other opiate problems (section III, table 12).

- In the 13 CEWG areas where data were available for 2008 and 2009, proportions of other opiate treatment admissions rose in all but 2 areas (Maine, where they decreased, and San Diego, where they were unchanged). From 2005 through 2009, 9 of the 10 CEWG areas with data for the 5-year period showed increases in other opiate admissions, ranging from 1.0 (Detroit) to 14.4 (Maine) percentage points. Baltimore (MSA) showed a 3 percentage-point decline in proportions of other opiate treatment admissions over the period, although these admissions increased statewide (section III, table 14).
- Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in 2009. In Atlanta, Baltimore (MSA), Maryland, Boston, Maine, Philadelphia, and Cincinnati, oxycodone ranked fourth in drug items identified, and it ranked fifth in New York City, Phoenix, and Seattle. Hydrocodone ranked fourth in Detroit and fifth in frequency of drug items identified in Atlanta, Cincinnati, San Diego, and Texas (table 2; section III, table 15).
- Buprenorphine ranked 5th in identified NFLIS drug items in Baltimore (MSA) and Maryland in 2009, 6th in Boston, 7th in Washington, DC, and Maine, 8th in Seattle, and 10th in New York City and Philadelphia (table 2).
- Methadone ranked in the top 10 identified drugs in New York City (7th), Baltimore (MSA) and San Francisco (8th each), and Maryland and Maine (9th each) during this reporting period (table 2).

### **Benzodiazepines/Depressants**

- *Increases in indicators for benzodiazepines were evident in CEWG areas in all regions of the country, and alprazolam and clonazepam continued to be the most frequently reported benzodiazepines in the 2009 indicator data.*

*Most of the CEWG area representatives who reported on benzodiazepines reported stable, mixed, or increasing indicators; none of the reporting areas had declines in benzodiazepine indicators.*

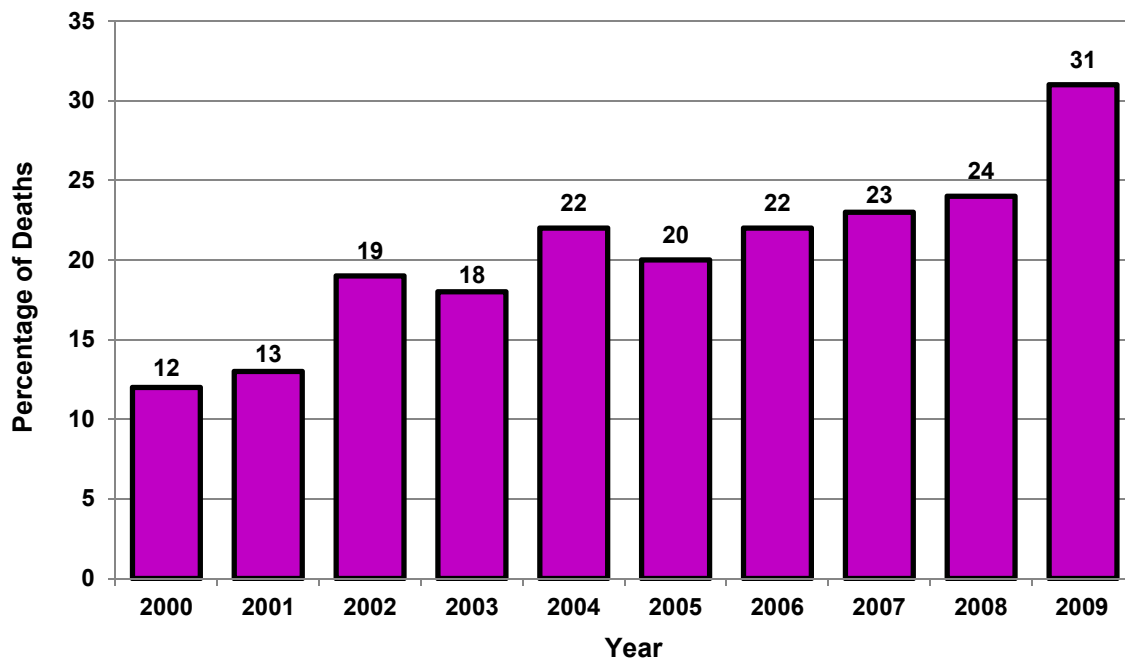
- The Boston area representative continued to report moderate to high levels of benzodiazepine indicators. NFLIS reports of drug items seized and identified as benzodiazepines (including clonazepam, alprazolam, diazepam, and lorazepam) increased in Boston from 2008 to 2009; the most common benzodiazepine identified continued to be clonazepam. The area representative from Maine reported mixed indicators for benzodiazepines, with deaths (figure 13) and primary treatment admissions being relatively high and increasing. Alprazolam was the benzodiazepine of choice in New York City and Philadelphia, as reported by these area representatives. Benzodiazepines as a group were fifth in the top five drugs mentioned at admission to treatment in Philadelphia, where benzodiazepines were said by the area representative to most likely be used in combination with marijuana or prescription opioids in 2009.
- In the southern region, alprazolam ranked third among drug items identified in NFLIS laboratories for 2008 and 2009. The Miami area representative reported high levels of alprazolam indicators with increasing consequences (deaths, DAWN *Live!* ED reports, and crime laboratory cases were all up in the most recent reporting period). According to the area representative, benzodiazepines in general, and alprazolam in particular, were a substantial problem in South Florida in 2009. Benzodiazepines were detected as present in 4,340 deceased persons across Florida in 2009, representing a 4-percent increase over the 4,167 cases in 2008. Alprazolam was the most frequently occurring drug found in decedents in Florida in 2009, with more than 90 percent of the cases also involving at least one other substance in combination.
- Alprazolam was also the benzodiazepine that appeared most frequently in the indicator data

in the midwestern region, according to area representatives in that region who reported on benzodiazepines for 2009. The Cincinnati area representative reported that abuse of benzodiazepine-based tranquilizers continued to be an increasing drug issue in that city. Qualitative indicators pointed to relatively high availability of these drugs, with some indication of stabilization occurring in 2009 from 2008 in that CEWG area.

- Benzodiazepine indicators remained relatively low in the western region, although some slight increases were observed in the 2009 reporting period in both Denver and Los Angeles. Several representatives from CEWG areas in the West reported on benzodiazepine-related deaths. While benzodiazepines were not among the most common drugs detected in Denver drug-related decedents, diazepam accounted for 5.9–11.1 percent of Denver drug-related deaths from

2005 to 2009. Alprazolam constituted from 5.9 to 9.7 percent of Denver drug-related deaths during the same 5-year time period. Alprazolam was also one of the drug items identified in forensic laboratories in Maricopa County, where numbers increased from 2007 to 2009 (from 47 drug items containing alprazolam in 2007 to 122 in 2009), along with oxycodone and hydrocodone, which also increased substantially in that period (figure 14). The Phoenix area representative reported that benzodiazepines were the fourth most common drug mentioned in drug-related deaths in that area. In Texas, qualitative data sources suggested increases in alprazolam in Houston, and it was the most common pill mentioned in San Antonio, according to street outreach workers there. Alprazolam is one of the three ingredients, along with hydrocodone and carisoprodol, that constitute the “Houston Cocktail” or “Holy Trinity” combination that has been reported in 2009 by area representatives from Detroit and Texas.

**Figure 13. Percentage of Deaths Due to Benzodiazepines Based on Medical Examiner Data, Maine: 2000–2009**



SOURCE: Office of the Medical Examiner, Maine as reported by Ma cella Sorg at the June 2010 CEWG meeting

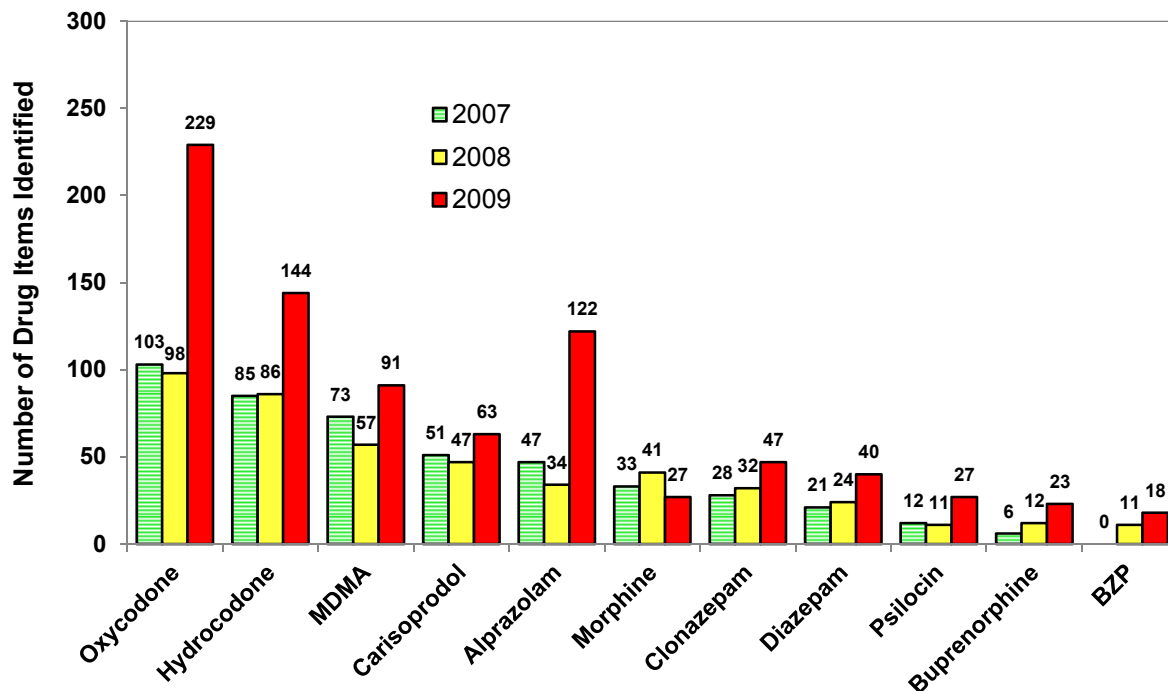


- Atlanta and Texas had the highest percentage of alprazolam drug items identified in forensic laboratories in 2009, at 5.0 and 4.6 percent, respectively (section III, table 16). Alprazolam ranked third in frequency among the top 10 drug items identified in forensic laboratories in Atlanta, and it ranked fourth in three CEWG areas: Miami, New York City, and Texas (table 2).
- Drug items containing clonazepam accounted for 2.7 percent of all drug items in Boston, where clonazepam figured as the fifth most frequently identified drug in forensic laboratories in 2009. It ranked seventh in Baltimore and Maryland and eighth in Philadelphia among drug items identified in the reporting period (table 2).
- Diazepam ranked 9th in San Diego in 2009, but did not rank in the top 10 most frequently identified in NFLIS forensic laboratories in any other CEWG area in 2009 (table 2).

## Methamphetamine

- Declining methamphetamine indicators in several CEWG areas reported in 2008 and the first half of 2009 continued for the whole of 2009. However, such indicators remained high, and methamphetamine continued as a drug of concern in CEWG areas in the western region.*
- In the 2009 reporting period, all area representatives in CEWG areas in the Northeast (Boston, Maine, New York City, and Philadelphia) reported low or very low levels of methamphetamine indicators, including those measuring availability or demand. In Boston in 2009, treatment admissions ( $n=35$  in 2009), calls to the drug helpline ( $n=12$ ), and laboratory samples identified as methamphetamine ( $n=66$ ) remained very low. Similarly, methamphetamine indicators remained low in New York City. Treatment admissions, DAWN Live! ED reports, and NFLIS items identified involving the drug were all reported at very low levels in 2009 by the area

**Figure 14** Number of Drug Items Identified in Forensic Laboratories in the NFLIS System, Maricopa County (Phoenix Area): 2007–2009



SOURCE: NFLIS, DEA, received 4/26/10, as reported by James Cunningham at the June 2010 CEWG meeting

representative. According to the Street Studies Unit, there was little methamphetamine availability or selling activity in New York City. The Philadelphia area representative reported that methamphetamine continued to be a relatively minor problem there in 2009. Only 0.01 percent of treatment admissions in Philadelphia were attributed to methamphetamine. In Maine, however, where methamphetamine numbers were still low and indicators were mixed, the area representative reported slight increases in arrests and drug items seized and identified as methamphetamine.

- Similarly, all CEWG areas in the southern region (Atlanta, the Baltimore/Maryland/ Washington, DC, area, and South Florida) reported low or very low levels and mostly stable indicators for methamphetamine.
  - While the Atlanta area representative reported other methamphetamine indicators (such as treatment admissions) as stable in Atlanta, drug items seized and identified as methamphetamine by NFLIS increased there in 2009 for the first time in 4 years. Methamphetamine continued to rank second in Atlanta in drugs seized and identified by NFLIS, after cocaine/crack, in 2009.
  - Methamphetamine indicators in South Florida remained relatively very low, and the area representative reported that South Florida had some of the highest prices for methamphetamine in the Nation in 2009, at \$15,000–\$30,000 per pound for powder Mexican methamphetamine and \$2,100 per ounce for Mexican ice.
  - The Baltimore/Maryland/Washington, DC, area representative reported that methamphetamine indicators in that CEWG area remained low and were confined to isolated communities in the District.
- Although still a drug more prominent in the West than in other regions of the country, methamphetamine remained a drug to monitor in the Midwest, according to area representatives.
  - The area representative from St. Louis reported that methamphetamine remained a primary drug of abuse in outlying, rural areas, where it appeared regularly in treatment data. Availability of the drug and the continuing presence of clandestine laboratories remained a concern. Qualitative data indicated that the influence of the distribution networks led to increased availability throughout the St. Louis region in 2009. Social networks with methamphetamine “cookers” were responsible for increases in numbers of clandestine laboratories in that area in 2009. Access to methamphetamine from Mexico and the Southwest was also considered by the area representative to be a component of the methamphetamine problem in the city and county of St. Louis and the surrounding five Missouri counties.
  - Although methamphetamine remained a drug of concern, the representative from the Minneapolis/St. Paul area reported continuing downward trends in the drug’s indicators in 2009. Methamphetamine-related admissions to addiction treatment programs accounted for 5.7 percent of total treatment admissions in the Twin Cities in 2009, compared with 6 percent in 2008 and 12 percent in 2005. There were 7 methamphetamine-related deaths in Hennepin County in 2009, compared with 20 in 2008. Seizures of methamphetamine by law enforcement officials were also on the decline.
  - Reversing previous trends, the Cincinnati representative reported a slight increase in methamphetamine indicators in 2009. There was a 75-percent increase in the number of clandestine methamphetamine laboratory seizures from 2008 to 2009, a trend that will need to be monitored closely for signs that a shift in use patterns may be occurring. An increase in house fires and explosions related to methamphetamine manufacture was reported to have occurred in central and southeastern Ohio in 2009, compared with the previous year.



- Elsewhere in the Midwest, in Chicago and Detroit, methamphetamine indicators continued to be low. Treatment and arrestee data and seizure indicators for methamphetamine declined in Chicago in 2009, according to the area representative. The Detroit representative suggested that compared with other drugs, methamphetamine was not a problem in that area.
- While most area representatives in the West reported stable or mixed indicators for methamphetamine, the area representative from Honolulu reported increasing methamphetamine indicators there in 2009, a reversal of the declining indicators reported in 2008. Both primary treatment admissions and methamphetamine-related deaths increased substantially in Hawaii in 2009. For example, 2009 primary methamphetamine treatment admissions in Hawaii totaled 3,692, compared with 2,726 in 2008.
  - Other CEWG areas in the western States reported stable or mixed methamphetamine indicators, with continuing high levels. In Denver, methamphetamine continued to rank as one of the top five drugs of concern in that area, as it had in 2007 and 2008. Indicators there were mixed, however, with a decrease in the supply reported by the area representative related to law enforcement crackdowns, which limited methamphetamine coming into Colorado from outside the State. The Denver area representative reported that methamphetamine was still predominant in the gay community there.
  - The Los Angeles area representative reported that methamphetamine continued to be one of the major drugs of abuse in the area, but indicators were reported to be stable in 2009, including treatment admissions (where 2009 showed a slight decrease to 17.7 percent of all admissions, from 19.0 percent in 2008) and drugs identified by NFLIS. However, availability increased in 2009, along with a decrease in wholesale prices (\$13,800–\$14,000 per pound in 2009, down from the 2008 range of \$17,500–\$19,000 per pound).
  - Methamphetamine indicators in Phoenix were mixed in 2009, according to the area representative, yet levels remained high. While primary treatment admissions for methamphetamine declined from 29 percent in 2007 to 21 percent in 2009, they still outnumbered those associated with any of the other illicit drugs, including cocaine, marijuana, and heroin/morphine. The Phoenix representative reported that “smurfing” operations (in which people are solicited to travel from store to store to purchase pseudoephedrine) acquire bulk quantities of pseudoephedrine in the Phoenix metropolitan area and then transport the precursor to California laboratories for methamphetamine production.
  - In San Diego, the area representative reported that the steady decreases in methamphetamine indicators seen since 2005 stabilized in 2009. Figure 15 shows the declines in the percentage of primary methamphetamine treatment admissions from 2005 to 2009, with a 1.5 percent decline shown in the 2008–2009 period. One exception there to the downward and stable trends for methamphetamine was found among prevalence data for arrestees, where 39 percent of females tested positive for methamphetamine in 2009, compared with 31 percent in 2008.
  - Although levels continued to be high in San Francisco, most indicators for methamphetamine (treatment admissions, weighted DAWN ED visits, and deaths related to methamphetamine) continued the downward trend in the bay area that began in 2006. The San Francisco area representative reported that treatment admissions remained close to the percentage of total admissions related to cocaine and heroin. For treatment admissions in the five-county San Francisco MSA in FY 2009, methamphetamine represented

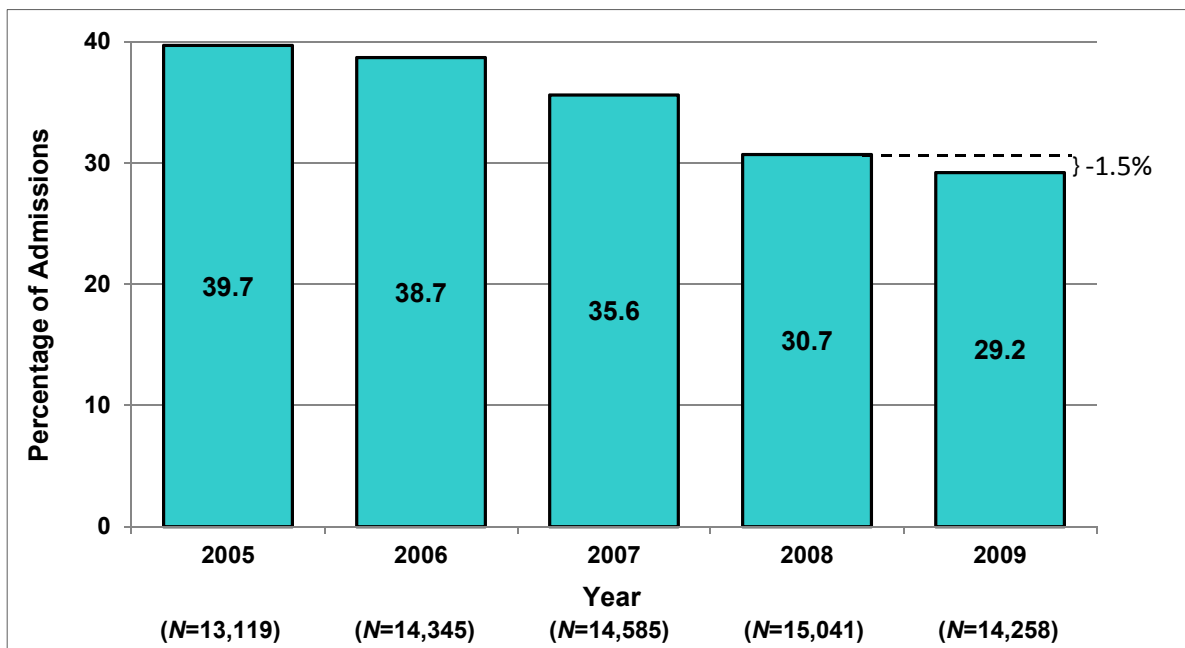
17 percent of all admissions, a decline from FY 2007, but still close to cocaine (21 percent) and heroin (18 percent).

- Methamphetamine indicators were mostly stable in the Seattle area, according to the area representative. Methamphetamine treatment admissions have remained essentially flat there among adults since 2005, while they have declined substantially among youth during the same time period. Fatalities involving methamphetamine were also level at approximately 20 per year since 2003. Qualitative data indicated that methamphetamine was mostly imported in 2009, but some small-scale local manufacturing continued.
- The Texas area representative reported that methamphetamine indicators (poison control data, treatment admissions, and methamphetamine-related deaths) continued

their steady decline that began in 2006. The area representative continued to report on innovative local production methods. With pseudoephedrine “easy to obtain” in Texas, according to the area representative, “one pot” and “shake and bake” methods continued to be common production methods. Methamphetamine was also coming into Texas from Mexico, according to the area representative.

- Most area representatives reported that treatment admissions for methamphetamine continued to be predominantly White, male, and age 34 or older. However, in San Diego, treatment admissions for methamphetamine were increasingly female; 47 percent of primary treatment admissions for methamphetamine were female in 2009, compared with 40 percent in 2005. In Los Angeles, increasing proportions of methamphetamine treatment admissions in the 35 and older age group are shown in figure 16. A

**Figure 15 Percentage of Primary Methamphetamine Treatment Admissions as a Percentage of All Admissions, San Diego: 2005–2009**



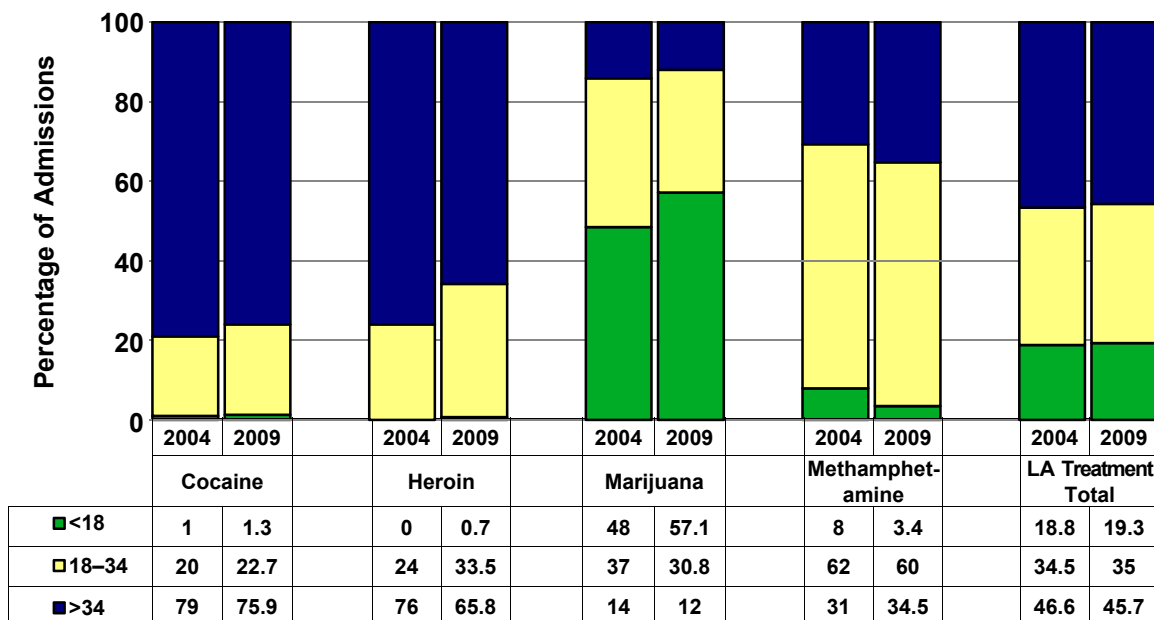
SOURCE: California Outcome Monitoring System (CalOMS)/California Alcohol and Drug Data System (CADDs), as reported by Robin Pollini at the June 2010 CEWG meeting

different age pattern was reported in Miami. Although methamphetamine was cited as the primary drug for addiction treatment among only 1 percent of treatment admissions in Miami/Dade County during 2009, three-fourths of those clients were younger than 18. The Denver area representative reported an increase there in Hispanic/Latino primary treatment admissions for methamphetamine. From 2000 to 2009, the proportion of Hispanic/Latino methamphetamine admissions rose from 8.5 to 18.9 percent statewide and from 7.0 to 15.4 percent in Denver. Denver area treatment admissions also tended to be younger; 19.2 percent of statewide treatment admissions and 18.8 percent of Denver admissions were younger than 25 in 2009. The Phoenix area representative reported that in Arizona from 2005 to 2009, the median age of amphetamine-related (including methamphetamine) admissions was lower for American Indians than for Whites, Latinos, or African-Americans. Among these latter three

ethnic groups, male admissions outnumbered female admissions, but the opposite was the case for American Indians.

- Smoking continued as the primary route of administration for methamphetamine in most CEWG areas. However, the area representatives from Atlanta and Chicago reported increases in injection of the drug in their areas.
- The proportions of primary treatment admissions, including primary alcohol admissions, for methamphetamine abuse in 17 reporting CEWG areas were especially high in Hawaii and San Diego, at approximately 42 and 29 percent, respectively. They were also relatively high in Phoenix and Los Angeles, with respective percentages of approximately 21 and 18 (section III, table 17).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego and Hawaii, second in Phoenix, third

**Figure 16. Trends in the Age Distribution of Treatment Admissions for Methamphetamine and the Three Other Most Prevalent Illicit Drugs in Los Angeles, by Percentage: 2004 (July–December)<sup>1</sup> and 2009 (July–December)**



<sup>1</sup>The two older age groups were estimated for 2004 because of a change in the age category definition.

SOURCES: Los Angeles County Alcohol and Drug Data System (CADDs) and California Outcome Monitoring System (CalOMS); and California Department of Finance, as reported by Ma y-Lynn Brecht at the June 2010 CEWG meeting

in Colorado and Denver, and fourth in Los Angeles and San Francisco (table 3).

- In all but 2 of the 14 CEWG areas reporting data, smoking was the most common route of administration of methamphetamine among primary treatment admissions; the 2 were Maine and Maryland (section III, table 18).
- In the 2-year period from 2008 through 2009, seven of the nine CEWG reporting areas had decreases in primary methamphetamine treatment admissions. Phoenix showed the largest decline in methamphetamine admissions (4.6 percentage points) from 2008 to 2009, followed by Seattle, with a decrease of 3.0 percentage points. Two areas, Hawaii and Atlanta, showed increases in methamphetamine admissions of 1.8 and 0.2 percentage points, respectively, during the period (table 20). In the 5 years from 2005 to 2009, all nine reporting areas saw declines in methamphetamine admissions; the largest declines were in Phoenix, San Diego, and Minneapolis/St. Paul, with respective percentage-point declines of 16.4, 13.2, and 10.8 (section III, table 20).
- In 2009, methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu; second in Atlanta, Minneapolis/St. Paul, Phoenix, and San Diego; and third in five CEWG areas: Denver, Los Angeles, San Francisco, Seattle, and Texas (table 2). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 39 percent), followed by Minneapolis/St. Paul (approximately 24 percent), San Francisco (approximately 22 percent), and Atlanta (approximately 21 percent). In contrast, less than 2 percent of drug items identified as containing methamphetamine were reported in 10 CEWG metropolitan areas east of the Mississippi, including Detroit, Chicago, Miami, New York City, Cincinnati, Boston, Philadelphia, Maryland, Baltimore, and Washington, DC (section III, figure 25; figure 22; appendix table 2).

## Marijuana/Cannabis

- *All CEWG areas continued to report high levels for marijuana indicators in 2009, and marijuana continued to be widely available across all CEWG areas. Only one area representative (Boston) reported downward trends for marijuana. These were attributed to a recent change in marijuana laws in Massachusetts that affected arrest and seizure data. Most CEWG areas reported increasing, stable, or mixed marijuana indicators.*
- Marijuana indicators in three CEWG areas in the Northeast remained high (Maine, New York City, and Philadelphia), while moderate levels were reported in Boston.
  - In the Boston area, the representative reported that substantial decreases in the proportion of marijuana arrests (from 35 percent in 2008 to 21 percent in 2009) and in the proportion of drug laboratory samples identified as marijuana (from 43 percent in 2008 to 24 percent in 2009) were attributed to a change in the Massachusetts marijuana possession law that decriminalized possession of an ounce or less of the drug. Those marijuana indicators (treatment admissions and drug helpline calls) not directly impacted by the change in Massachusetts' marijuana possession law were fairly stable. Treatment admissions citing marijuana as the primary drug of abuse remained between 3 and 4 percent of all treatment admissions from 2000 to 2009, but combined marijuana primary and secondary drug admissions increased from 9 percent in 2008 to 11 percent in 2009.
  - The Maine area representative reported continuing high levels and mixed indicators for marijuana. Primary treatment admissions for marijuana were down slightly, from 18 percent in 2008 to 16 percent in 2009, but marijuana-related arrests increased from 2008 to 2009 (from 17 to 22 percent).
  - Primary treatment admissions for marijuana increased in New York City to the highest

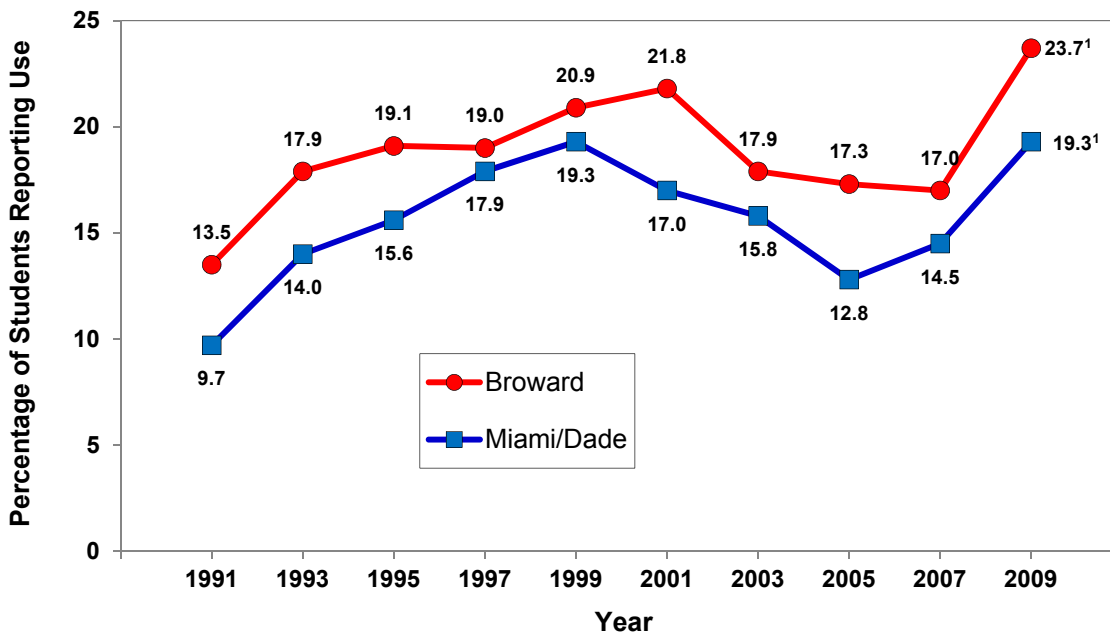
level ever reported and represented one-quarter of all substance abuse treatment admissions in 2009.

- The shift from cocaine to marijuana as the leading drug of choice in Philadelphia that was noted in 2008 continued in 2009, according to the CEWG representative from that area. Marijuana was the most commonly used illicit drug in Philadelphia, ranking first in treatment admissions, drugs seized and identified by NFLIS laboratories, and in Adult Probation/Parole Department urinalysis data.
- All CEWG area representatives in the South reported high levels of marijuana indicators. In 2009, marijuana was the most commonly abused substance in Atlanta, where primary treatment admissions for marijuana (at 23.3 percent) surpassed cocaine admissions for the first time in 10 years. Marijuana indicators in the Baltimore/

Maryland/Washington, DC, area were high and mixed. The Miami area representative reported that marijuana indicators in the Miami/Dade and Broward County areas remained high. YRBS data on self-reported past-30-day use of marijuana among Miami/Dade and Broward County high school students also showed statistically significant increases over the time period from 1991 to 2009, and most recently from 2007 to 2009 (figure 17).

- Marijuana indicators in the Midwest continued to be high and increasing or stable. Most indicators for marijuana for the Chicago, Cincinnati, and Detroit areas were high and mostly stable. In Chicago, marijuana was the predominant drug item analyzed by NFLIS in 2009, representing 58 percent all drug items (unchanged from 2008). In Detroit, primary treatment admissions for marijuana increased from 13.7 percent of all admissions in 2008 to 17 percent in 2009. The Minneapolis/St. Paul area representative

**Figure 17. Percentage of High School Students Reporting Any Past-30-Day Marijuana Use, Miami/Dade and Broward Counties: 1991–2009**



<sup>1</sup>Statistically significant differences are observed for both Miami/Dade and Broward County students surveyed for 1991 to 2009 and 2007 to 2009.

SOURCE: YRBSS, CDC, as reported by James Hall at the June 2010 CEWG meeting



- similarly reported that marijuana continued to account for more admissions to addiction treatment programs in the Twin Cities area than any other drug except alcohol, representing 3,744 admissions in 2009 (18.1 percent of total addiction treatment admissions), compared with 3,199 admissions (16.6 percent of the total) in 2008.
- All of the CEWG area representatives in the West reported high and increasing or stable marijuana indicators. Percentages of primary treatment admissions for marijuana were increasing in several areas in the western region.
    - Marijuana accounted for the highest proportion of treatment admissions in Denver and statewide in Colorado annually since 2000 (37 percent of admissions statewide in 2009, compared with 35 percent in 2007, and 38 percent of Denver admissions in 2009, compared with 37 percent in 2007).
    - Similarly, in Honolulu in 2009, marijuana-related treatment admissions and ME toxicology cases both increased compared with 2008.
    - In Los Angeles, marijuana treatment admissions increased from 17 percent in 2007, to 20 percent in 2008, to 23 percent in 2009.
    - The San Diego area representative reported a continuing increase in the proportions of primary treatment admissions for marijuana since 2007. In 2009, they constituted almost 20 percent of all admissions, compared with 15.6 percent in 2007 and 18.9 percent in 2008.
    - Treatment admissions were also up substantially in the Seattle area, where the number and rate of treatment admissions among adults has more than doubled since 1999 (from 620 admissions in 1999 to 1,715 in 2009).
  - Several CEWG area representatives reported shifts in the age, gender, and ethnicity of primary marijuana treatment admissions.
    - A continuing increase in younger marijuana treatment admissions was reported by several area representatives across all CEWG regions. In Maine, a slight increase in marijuana primary treatment admissions for clients 17 and younger was reported by the area representative (from 27 percent of all admissions in 2008 to 30 percent in 2009). The proportion of younger marijuana users in the Atlanta area increased between 2008 and 2009, with 63 percent of those seeking treatment for marijuana being younger than 26. Marijuana continued to be the most frequently found drug among juvenile arrestees whose urine was tested by the Washington, DC, Pretrial Services Agency. Approximately 52 percent of juvenile arrestees tested positive for marijuana in 2009, and 55 percent were marijuana-positive during the first 4 months of 2010 (in 2008, 54 percent of juvenile arrestees tested positive for marijuana). In Miami/Dade and Broward Counties, primary treatment admissions for marijuana accounted for 87–88 percent of all primary admissions (including alcohol) among youth younger than 18. Approximately one-half of all primary marijuana treatment clients in Miami/Dade County were younger than 18. The St. Louis area representative reported continuing marijuana popularity among young adults, along with the view that marijuana use is acceptable. Almost two-thirds of clients admitted to treatment in St. Louis in 2009 were referred by the courts. The 25-and-younger age group accounted for 55.9 percent of primary marijuana treatment admissions in 2009 in St. Louis.
    - Younger treatment admissions for marijuana than for other drugs were noted throughout the western region. In both Colorado and the Denver metropolitan area, marijuana users were typically the youngest of the treatment admissions groups. In 2009, the average age of marijuana users entering treatment was 24.6 (median age was 22)

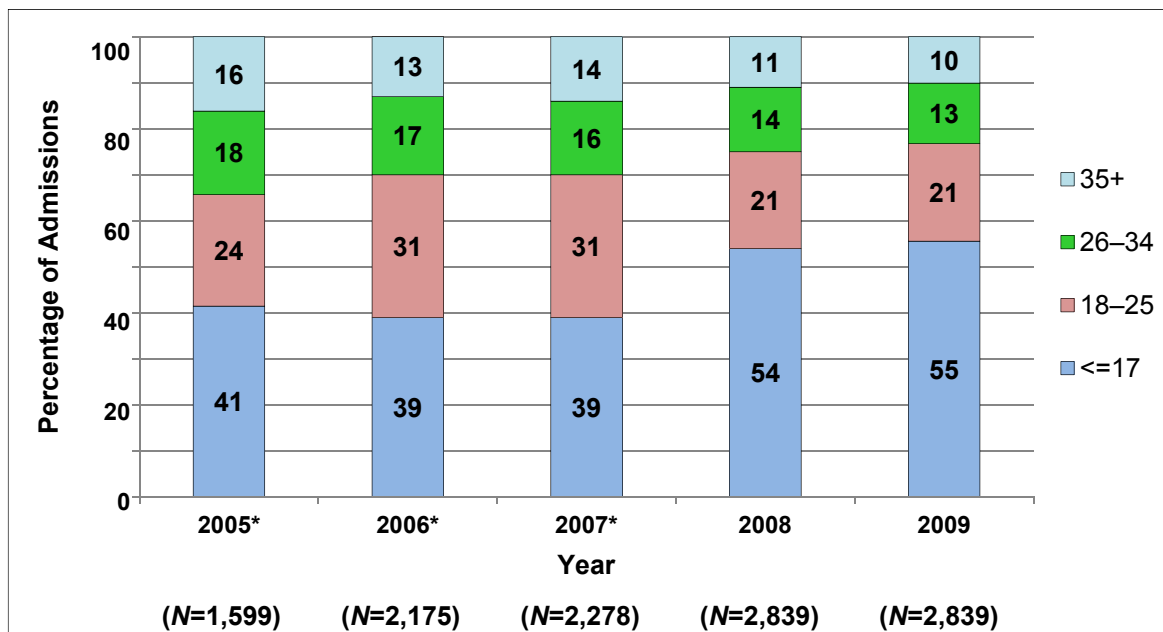


statewide and 23.9 (median age was 21) in Denver. More than one-half (57 percent) of marijuana admissions in Los Angeles were adolescents younger than 18 in 2009, compared with 53.8 percent of marijuana admissions in 2008 and 48.0 percent in 2004 (figure 16). The prevalence of marijuana use among juvenile arrestees, based on toxicology testing, increased substantially in 2009 in San Diego, with 51 percent testing positive, compared with 44 percent in 2008. Also in San Diego, figure 18 shows percentages of primary treatment admissions for marijuana increasing among youth 17 and younger, from 41 percent of all treatment admissions in 2005 to 55 percent in 2009. In Seattle, marijuana continued as the most common primary drug among youth entering drug treatment (at 64 percent of all youth drug treatment admissions in 2009), with

percentages of adult marijuana admissions increasing in recent reporting periods.

- Some representatives from CEWG areas in the Northeast and Midwest, however, reported decreases in young admissions to treatment for marijuana. The Boston area representative reported a decrease in client admissions among those younger than 26 in that area, from 62 percent in 2000 to 48 percent in 2009. The proportion of client admissions age 35 and older increased from 13 percent in 2001 to 24 percent in both 2006 and 2009. Declines were also noted in Detroit and Chicago in the Midwest. Approximately one-fourth of Detroit area marijuana treatment admissions in 2009 (28.6 percent) were younger than 18, which represented a decline from FY 2007, when they constituted 38.7 percent of all admissions. Recently reported results of the CDC

**Figure 18. Percentage<sup>1</sup> of Primary Treatment Admissions for Marijuana, by Age Group<sup>2</sup>, San Diego: 2005–2009**



<sup>1</sup>Percentages are rounded to the nearest whole number.

<sup>2</sup>Age categories changed at the upper end in 2008 and 2009 to 26–34 and 35 and older; before that, these age categories were 26–35 and >35 (as indicated by asterisks (\*) after the years, 2005, 2006, and 2008).

SOURCE: California Outcome Monitoring System (CalOMS)/California Alcohol and Drug Data System (CADDs), as reported by Robin Pollini at the June 2010 CEWG meeting

YRBS survey for 2009 showed that lifetime marijuana use reported by students in Chicago high schools declined 17 percent since a 2001 peak of 49.3 percent. In 2009, 41.0 percent of students in Chicago reported ever smoking marijuana, the lowest level since the 1995 survey (33.7 percent).

- Across CEWG areas, marijuana treatment admissions continued to be predominantly male, a proportionate share that was increasing in some areas. An increase in male primary treatment admissions from 2008 to 2009 (from 71 to 82 percent) was reported in Boston. Similarly, in St. Louis, the percentage of male marijuana treatment admissions increased from 65 percent in 2008 to 77 percent in 2009.
- In several CEWG areas in the Northeast, South, and Midwest, representatives reported a continuing trend toward increasing proportions of African-American marijuana treatment admissions. From 2008 to 2009, the racial/ethnic distribution in the Boston area shifted to an increasing proportion of African-Americans among primary marijuana admissions (from 39 percent in 2008 to 48 percent in 2009) and a corresponding decrease in the proportion of White marijuana admissions (from 29 percent in 2008 to 21 percent in 2009). Elsewhere in the Northeast, primary treatment admissions for marijuana remained predominantly African-American in Philadelphia, representing 76.9 percent of treatment admissions for marijuana in 2009, compared with 77.5 percent in 2008. In the South, in Atlanta, the proportion of African-Americans who identified marijuana as their primary drug of choice continued to increase, from 53.8 percent in 2007, to 58.2 percent in 2008, and 61.0 percent in 2009. Nearly twice the proportion of African-Americans reported marijuana as their primary reason for admission compared with Whites. In the Midwest, in Detroit in 2009, 90.7 percent of primary marijuana treatment admissions were African-American, compared with 92.9 percent in 2008. In the Minneapolis/St. Paul Twin Cities area, where 84 percent of the population is White, the representative reported that 54.1 percent of marijuana treatment admissions were White in 2009, while 30.5 percent were African-American. In the West, the Denver area representative reported mostly White treatment admissions for marijuana in 2009; African-American admissions in the Denver area represented a 20.3 percent share. Hispanic clients in treatment for marijuana, however, continued to represent nearly one-third of Denver treatment admissions, at 31.4 percent in 2009 (they represented 30.2 percent in 2007 and 31 percent in 2008).
- The area representative for New York City reported that marijuana in a blunt cigar continued to serve as the base to which other drugs were added. Using blunt cigars for smoking marijuana was also reported by area representatives from Philadelphia and Phoenix. The Texas School Survey of Substance Abuse: Grades 7–12, 2008, as reported by the Texas area representative, showed that of those youths who used marijuana, 66 percent smoked blunts at least one-half of the time, compared with 58 percent who smoked “joints” at least one-half of the time. The Philadelphia area representative noted that clients entering treatment for marijuana abuse reported that marijuana was commonly used in combination with PCP (phencyclidine) or cocaine, either in a blunt or separately. According to the Minneapolis/St. Paul area representative, marijuana joints dipped in formaldehyde, which is often mixed with PCP, are known as “wet sticks,” “water,” or “wet daddies.” Joints containing crack are known as “primos.”
- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in 2009 in Miami/Dade County (38.2 percent) and Broward County

(35.8 percent), followed by Hawaii (28.7 percent), Philadelphia (25.7 percent), and New York City (25.0 percent). The lowest proportions of such admissions were in Boston (4.4 percent) (section III, table 21).

- Marijuana ranked first as the primary drug problem in total drug admissions, including alcohol admissions, in 3 of 22 CEWG areas; these were Miami/Dade and Broward Counties, Philadelphia, and Los Angeles. Marijuana ranked second among primary drugs of admission in eight additional areas: Atlanta, Cincinnati, Minneapolis/St. Paul, Denver, Seattle, and the States of Colorado, Hawaii, and Texas (table 3).
- Increases in percentages of primary marijuana treatment admissions, excluding alcohol admissions, occurred in 11 of 14 CEWG reporting areas from 2008 to 2009, although only 2 (Los Angeles and Seattle) approached or exceeded 5 percentage points. However, over the 5 years from 2005 to 2009, primary marijuana treatment admissions increased in 12 of 14 reporting areas, with the largest increases noted for Los Angeles, San Diego, and New York City (at 11.2, 9.8, and 9.5 percentage points, respectively) (section III, table 23). Increases ranging from 5 to 8 percentage points were observed in Atlanta, Detroit, Hawaii, Minneapolis/St. Paul, Phoenix, Seattle, and Texas from 2005 to 2009, with an increase of less than 1 percentage point in Denver. Declines in marijuana admissions were observed for two areas, Maine and Baltimore, with the decrease for Maine at approximately 9 percentage points, compared with less than 1 percentage point for Baltimore over the 5-year period (section III, table 23).
- Cannabis/marijuana ranked in either first or second place in frequency in the proportion of drug items identified in forensic laboratories in 2009 in all CEWG areas, with the exception of Maine and Atlanta. Cannabis ranked in first place among identified drugs in 14 of 22 CEWG areas in this reporting period: Baltimore, Maryland, Philadelphia, Detroit, Chicago, St. Louis, Cincinnati, Minneapolis/St. Paul, Los Angeles, Phoenix, San Diego, San Francisco, Seattle,

and Texas. It ranked second in the remaining six areas (table 2). The highest proportions of marijuana items identified in the NFLIS system were in Chicago and San Diego, at approximately 58 and 52 percent, respectively (section III, figure 26; appendix table 2).

## **MDMA/Ecstasy and Other Club Drugs, Including MDA, GHB, LSD, and Ketamine**

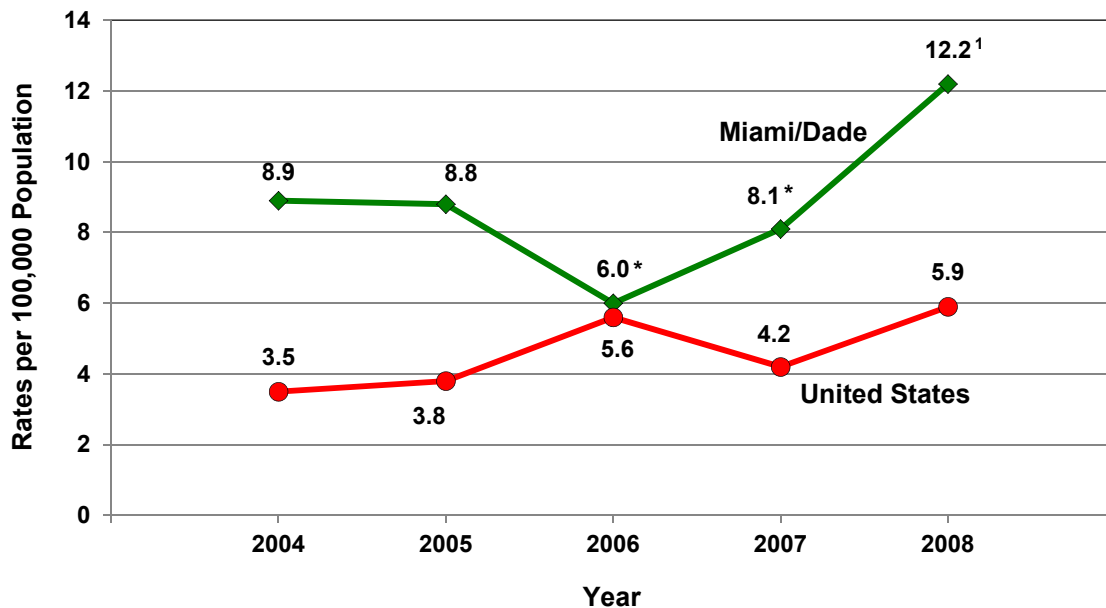
### **MDMA/Ecstasy and MDA**

- *MDMA (3,4-methylenedioxymethamphetamine) indicators continued to be low across all CEWG regions when compared with most other drug indicators. However, MDMA remained a persistent problem in several CEWG areas, as reported by area representatives, including those from Chicago, Cincinnati, Detroit, Miami, Minneapolis/St. Paul, and Seattle. A slight upward trend in indicators was reported in 2009 in two CEWG areas in the Northeast (Maine and New York City) and two areas in the West (Los Angeles and San Francisco) in 2009.*
- All area representatives in the northeastern region continued to report low levels of MDMA, with stable or mixed indicators. Although proportions of MDMA treatment admissions and weighted DAWN ED MDMA-involved visits remained low in New York City, and treatment admissions, deaths, and arrests remained very low in Maine, MDMA continued its move up in rank of drugs seized and identified in the NFLIS system in those two areas. In Maine, MDMA moved from 15th place in 2007 to 6th place in 2009; in New York City, MDMA ranked 6th in frequency of drug items identified in 2009, compared with 10th in 2008 (table 2; appendix table 2).
- According to the Philadelphia area representative, deaths with the presence of MDMA and MDA (3,4-methylenedioxymphetamine) were down in that city in 2009, compared with 2008. For MDMA, there were seven such deaths in

2009, compared with nine in 2008; there were six deaths with the presence of MDA in 2009, compared with eight in 2008. Similarly, the Miami area representative reported that state-wide in Florida, MDMA deaths decreased by 27 percent, and MDA deaths decreased by 39 percent, between 2008 and 2009. Figure 19 shows increases in the rates of estimated MDMA-involved ED visits in Miami/Dade County from 2004 to 2008 from the DAWN data system.

- Elsewhere in CEWG areas in the southern region, the Atlanta representative reported that between 2008 and 2009, a decrease in MDMA was reflected in several indicators—data from the State Medical Examiner’s office, number of drugs seized and identified by NFLIS laboratories, and reports to the Georgia Poison Control Center. MDMA accounted for a very small percentage of treatment admissions in Atlanta.
- All areas in the midwestern region had continuing low levels of MDMA. The Chicago area representative reported that MDMA remained popular in low-income neighborhoods in the city. In Cincinnati, where MDMA availability reportedly remained at a moderate level, indicators decreased slightly in 2009. In Detroit, MDMA remained somewhat available, according to the area representative, and a law enforcement focus group reported that the drug was being imported from Canada. The St. Louis representative reported continuing anecdotal evidence of MDMA availability in clubs and colleges in the St. Louis region in 2009.
- Levels of MDMA indicators were reported as low in all areas of the western region, but some area representatives reported it as a drug of concern in their areas, including Los Angeles, San Francisco, and Seattle. In Los Angeles, although MDMA-related treatment admissions remained at a relatively low level (as in the past), they increased

**Figure 19 Rates per 100,000 Population of Estimated MDMA-Involved Emergency Department Visits, Miami/Dade County and the United States: 2004–2008**



¹Rates for Miami/Dade County are statistically significantly higher in 2008 than in 2006 or 2007 (indicated by the symbol \*). No significance testing of data for 2005 versus 2008 was available  
 SOURCE: OAS, SAMHSA, 2008 DAWN weighted ED estimates, received 4/24/10, as reported by James Hall at the June 2010 CEWG meeting

slightly in 2009 over 2008. Weighted DAWN ED visits for MDMA were estimated to have increased in the San Francisco Bay area by 56 percent from 2007 to 2008, according to that area representative. Again, while MDMA indicators remained relatively low in the Seattle area, seizures of MDMA shipments entering the United States through Washington from Canada were common; approximately 5,000,000 MDMA tablets were seized at the border in 2009. A slight increase in MDMA indicators in Phoenix reported for the first half of 2009 by the area representative was not sustained through the end of 2009.

- Representatives from Seattle and Miami/South Florida continued to report evidence that MDMA was often adulterated and marketed in combination with other drugs. The area representative from South Florida continued to report anecdotal information on increases in methamphetamine and BZP (1-benzylpiperazine) in ecstasy pills, usually without MDMA. The Seattle representative noted that, according to the Washington State Crime Laboratory, BZP and TFMPP (1-3-(trifluoromethylphenyl) piperazine) remained common adulterants in MDMA tablets.
- MDMA was the club drug most frequently reported among NFLIS data in the 22 CEWG areas in 2009 (section III, table 24).
- MDMA was the fourth most frequently identified drug item analyzed by NFLIS in Chicago and Minneapolis/St. Paul in 2009. It ranked 5th in 5 of 22 reporting areas: Detroit, Denver, Honolulu, Los Angeles, and San Francisco (table 2).
- MDA was reported among the drug items identified in 8 of 22 areas in 2009: Atlanta, Denver, Honolulu, New York City, Philadelphia, San Diego, San Francisco, and Seattle, although numbers were low in all cases (section III, table 25).

## Other Club Drugs (GHB, LSD, and Ketamine)

### GHB

- *GHB (gamma hydroxybutyrate), a concentrated liquid abused for its stupor-like depressant effects, is also used as a drug-facilitated rape drug. Area representatives from Boston, Atlanta, and South Florida reported that GHB was available in their areas, but that indicators were low. The Miami representative reported that indicators in that area have declined steadily since GHB was declared a federally controlled Schedule I drug in March 2000.*
- NFLIS-identified GHB drug items were reported in 7 CEWG areas of the 22 reporting, including Atlanta, Chicago, Los Angeles, New York City, San Diego, San Francisco, and Texas in 2009. Again, numbers were very low (section III, table 25).

### LSD

- *Although LSD (lysergic acid diethylamide) is still reported in some CEWG areas, including Atlanta, Minneapolis, St. Louis, and Phoenix, indicators for LSD (or “acid”), a strong, synthetically produced hallucinogen, were decreasing in those four areas. The area representative from St. Louis, however, reported that over the years LSD has sporadically reappeared in local high schools and rural areas.*
- LSD was not among the top 10 drugs reported in the NFLIS system for any CEWG reporting area, but it was identified among drug items seized in all but 4 of the 22 CEWG areas. These four exceptions are Detroit, Honolulu, Minneapolis/St. Paul, and Washington, DC. Only one area, Texas, had 30 or more cases, and in no area was the percentage at 1 percent of drug items identified (section III, table 25).

### Ketamine

- *Ketamine, also known as “Special K,” is a veterinary anesthetic that emerged as a drug of abuse in the 1990s. Like GHB, ketamine has been*



*described in past CEWG reports as a popular drug among young adults. Reports of ketamine abuse were rare across all CEWG areas in 2009.*

- Ketamine was identified among drug items in the NFLIS system in 2009 in 18 of 22 areas, in all but Boston, Honolulu, Minneapolis/St. Paul, and St. Louis (section III, table 25). While ketamine represented less than 1 percent of total drug items identified in any reporting area, 4 areas reported 30 cases or more: Texas, New York City, San Francisco, and Los Angeles (table 25). Ketamine did not figure among the top 10 most frequently identified drug items in any CEWG area (table 2).

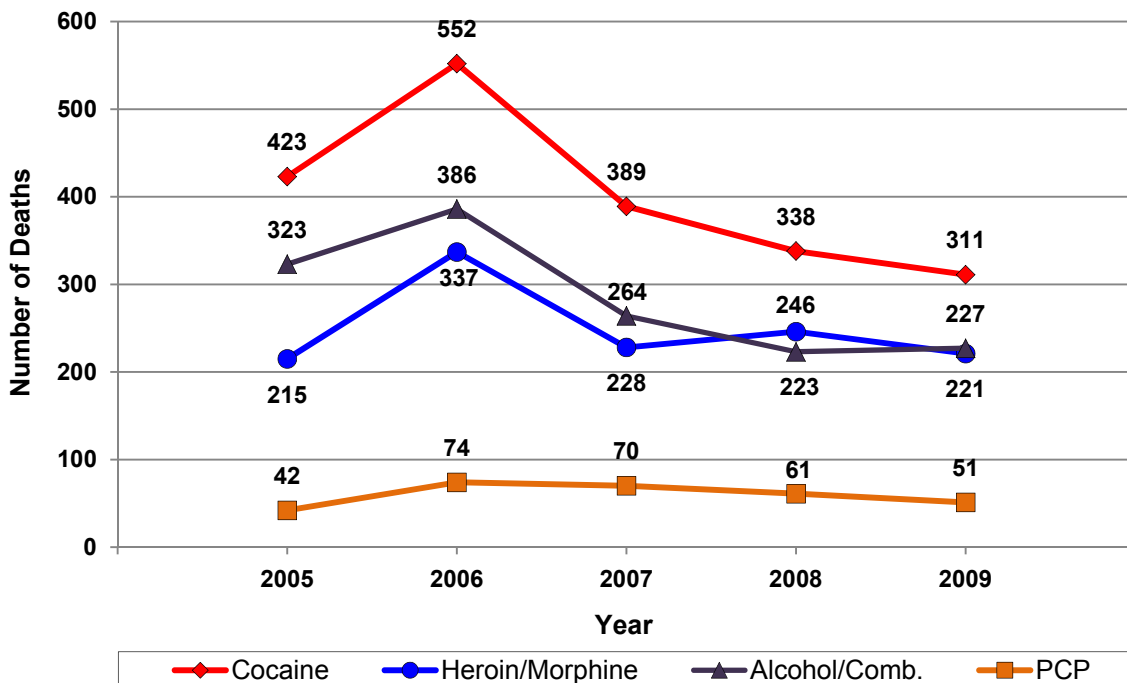
## PCP

- *PCP (phencyclidine) persisted on the drug scene in several CEWG areas, across all CEWG regions. It remained a drug of concern in the Baltimore/Maryland/Washington, DC, area and Philadelphia, and representatives from New*

*York City and Texas reported a continuing increase in PCP indicators.*

- The New York City representative reported significant increases in weighted DAWN ED visits for PCP from 2004 to 2008. In Philadelphia, PCP indicators were reported as mixed for 2009. Proportions of PCP-related treatment admissions increased from 2 percent in 2006 to 3.9 percent in 2009, and Adult Probation/Parole Department PCP urinalysis positivity increased among adults on probation or parole in 2009. However, deaths with the presence of PCP declined in 2009, compared with 2008 in that area (figure 20). In 2009, the majority of primary treatment admissions for PCP in Philadelphia continued to be male (81.5 percent, stable from 2008) and African-American (70 percent, compared with 68.5 percent in 2008).
- The representative from the Baltimore/Maryland/Washington, DC, area continued to report fluctuating PCP indicators across the CEWG

**Figure 20. Number of Deaths With the Presence of Selected Drugs in Philadelphia: 2005–2009**



NOTE: The fentanyl outbreak in Philadelphia was from April 2006 to April 2007.

SOURCE: Philadelphia Medical Examiner's Office, as reported by Samuel Cutler at the June 2010 CEWG meeting



area, with PCP being seen as particularly persistent as a drug of concern in Washington, DC. Washington, DC, Pretrial Services data, for instance, revealed an increase in the percentage of adults testing positive for PCP in the first 4 months of 2010, compared with 2009, while showing a decrease in the percentage of juvenile arrestees testing positive in 2009 and early 2010, compared with 2008.

- In Texas, where PCP indicators had increased slightly since 2008, PCP use was reported by street outreach workers to be increasing among youths and young adults age 16–30. It continued to be a problem throughout the State, but particularly in Houston. PCP treatment admissions entering treatment in Texas were predominantly African-American in 2009, as in past reporting periods.
- The area representative from St. Louis reported continuing PCP use in the inner city, where it remained an indigenous drug of choice. The highest percentages of PCP treatment admissions in St. Louis were African-American. In Los Angeles, PCP continued to rank seventh in drugs seized and identified by NFLIS laboratories, as it had in 2008. The Chicago area representative also reported a continuing PCP presence in indicators. Numbers of PCP-related treatment admissions increased from 60 in 2007 to 126 in 2009 in Chicago. The majority of primary treatment admissions for PCP in the Chicago area continued to be African-Americans (86 percent, an increase over 74 percent in 2007); females in treatment for PCP increased from 32 percent in 2007 to 63 percent in 2009 there.
- Two area representatives reported decreasing indicators for PCP. In Phoenix, drugs identified by NFLIS as PCP decreased in 2009 (10 drug items) from 2008 (19 drug items). The San Francisco area representative reported that weighted DAWN ED visit data for 2006–2008 reflected a steady, low, and possibly declining, frequency of PCP-involved visits in that area.
- PCP was most commonly used as an additive to marijuana blunt cigars in Philadelphia, based on ethnographic studies reported on by that area representative. In Minneapolis/St. Paul, St. Louis, and Texas, PCP was used as a dip for marijuana joints, according to the area representatives' reports.
- As a percentage of all NFLIS-identified items, PCP items were highest in Washington, DC, at 5.9 percent, followed by Philadelphia, at 2.6 percent, New York City, at 1.2 percent, and Los Angeles, at 1.0 percent (section III, table 25).
- In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in 2009. PCP was also among the top drug items identified in Philadelphia, where it ranked sixth. In 2009, PCP ranked 7th in Los Angeles, 8th in New York City, 9th in Chicago, and 10th in Maryland (table 2).

### **Spotlight on New Substances: Spice, K2, and Synthetic Cannabinoids; BZP; and Mephedrone and Synthetic Cathinones**

A special session at the June 2010 CEWG meeting, "New Drugs: United States and International Perspectives," examined the issue of new synthetic drugs emerging in the United States and in the global drug marketplace. A representative from the DEA discussed forensic laboratory data and drug scheduling pertaining to selected substances listed as DEA Drugs and Chemicals of Concern. Chris Rosenbaum, M.D., from the University of Massachusetts Medical Center, discussed the recent emergence of plant-based products that are smoked or inhaled for purported psychoactive effects and are known under various names, including "K2" and "Spice." He presented the emerging clinical picture and issues to be considered for future monitoring. Chris Wilkins, Ph.D., a senior researcher at the Centre for Social and Health Outcomes Research and Evaluation at Massey University in Auckland, New Zealand, presented findings from research on BZP (1-benzylpiperazine) use and self-reported consequences in New Zealand, and

discussed New Zealand's response to an increase in the recreational use of BZP in that country. An overview of the European Union's Early Warning System on new synthetic drugs was presented by Paul Griffiths, M.Sc., the Scientific Coordinator for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, Portugal, using mephedrone, a synthetic psychoactive substance, as a case study.

Highlights from the panel presentations are summarized in this section. Information from CEWG area reports, although not presented during the panel session, is incorporated in the following summary to provide a more complete picture of these evolving issues.

A framework for consideration of the panel topic, based on recent experience in the European Union (EU), was presented by the representative from the EMCDDA. In the EU, the Early Warning System (EWS) on new synthetic drugs has served as a system for detection, identification, and initial assessment of new psychoactive drugs for 12 years. The number of newly identified, psychoactive substances is increasing; 24 new substances were officially "notified" in 2009, compared with approximately 120 substances notified over the past 12 years. Several unregulated synthetic compounds that mimic the effects of known illegal drugs, and have been perceived as "legal highs," have captured the attention of the EU's EWS. Mr. Griffiths noted that issues to consider in the "legal high" phenomenon include the observations that these substances are advertised with aggressive and sophisticated marketing (targeting specific groups), they are in some cases mislabeled, and the suppliers adapt quickly to controls. Recent efforts of the EU system have resulted in the monitoring and assessment of the emergence of new, smokable herbal products laced with

synthetic cannabinoids (Spice), as well as BZP, and the growing popularity of synthetic cathinones (including mephedrone).

### Spice, K2, and Synthetic Cannabinoids

- An herbal mixture called Spice has been sold in European countries since the mid-2000s and has recently been encountered in the United States. Though labeled as incense and "not for human consumption," Spice products have been smoked by consumers and reported by some users to have effects similar to those of cannabis<sup>8</sup>. Samples of Spice tested in Europe and the United States have been found to contain synthetic cannabinoids<sup>9</sup>. The DEA has placed "spice cannabinoids" on the DEA list of Drugs and Chemicals of Concern. Reportedly, users consider synthetic cannabinoids as legal alternatives to marijuana. However, depending on the chemical structure, specific compounds (such as Hu-210) may be covered under the Controlled Substances Act and therefore may be illegal in the United States<sup>10</sup>.
- Reports in the United States of consequences associated with the use of K2 drew public health and media attention in early 2010. K2 is considered a Spice-like product viewed as a legal marijuana alternative. Such products are marketed under various names and can be acquired over the Internet or in specialized shops where they are sold as plant products or incense. Dr. Chris Rosenbaum discussed preliminary findings from research into poison control center reports of cases involving K2 exposures. It is suspected that the products identified as K2 contained synthetic cannabinoid compounds; however, it is not known exactly what is contained in these products. Clinical effects of reported exposures included agitation, tachychardia, nausea, and

<sup>8</sup>European Monitoring Centre for Drugs and Drug Addiction, *Thematic Papers: Understanding the "Spice" phenomenon*, Lisbon, Portugal, November 2009. Available at: [http://www.emcdda.europa.eu/attachements.cfm/att\\_80086\\_EN\\_Spice%20Thematic%20paper%20—%20final%20version.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_80086_EN_Spice%20Thematic%20paper%20—%20final%20version.pdf)

<sup>9</sup>Drug Enforcement Administration, Microgram Bulletin, March 2009, available at: <http://www.justice.gov/dea/programs/forensicsci/microgram/mg0309/mg0309.html>.

<sup>10</sup>Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, [http://www.dea-diversion.usdoj.gov/drugs\\_concern/spice/index.html](http://www.dea-diversion.usdoj.gov/drugs_concern/spice/index.html).

vomiting. Dr. Rosenbaum explained that synthetic cannabinoids are not detected by standard drug tests and stressed the need for better methods to detect these compounds in the clinical context. A better understanding is needed of what is in these products and the effects they have on humans.

- In the western region, the CEWG representative from Texas reported that between January 1 and June 30, 2010, the Texas Poison Center Network received calls involving 87 exposures to marijuana homologues (synthetic cannabinoids). The age range of exposure cases was between 13 and 40; 31 percent were younger than 20 and 82 percent were male. Effects reported included tachycardia, agitation, vomiting, and confusion. Elsewhere in the West, the Denver representative noted anecdotal information from adolescent treatment programs indicating local adolescent use of substances referred to as Spice, K2, and “Summit.”
- In the Minneapolis/St. Paul area, several high school students in a northern suburb reported adverse effects due to inhalation of K2, and one student experienced seizures from the incident, according to a local news report referenced by the area representative. Products purported to contain synthetic cannabinoids were reported to be widely available in South Florida, based on helpline calls and information from treatment counselors and probation officers, according to the area CEWG representative.
- The representative from the EMCDDA reported that in the EU new synthetic cannabinoids continue to appear. He noted that there is limited knowledge regarding the effects and toxicity of these substances.

## BZP

BZP is a synthetic stimulant that is illegal, has no accepted medical use in the United States, and

was controlled in 2004 as a schedule I substance under the Controlled Substances Act (CSA). It is reportedly often combined with TFMPP (1-3-(trifluoromethylphenyl)piperazine), a noncontrolled substance, with the aim of enhancing its effects as a substitute for MDMA.

- Across the Nation, the number of drugs seized and identified as BZP by NFLIS laboratories increased from 437 in 2007 to 13,822 in 2009<sup>11</sup>, suggesting a marked increase in the availability of BZP in the illicit market. Table 1 shows increases in BZP NFLIS items in CEWG areas from 2007 through 2009.
  - In 2007, BZP was identified in 10 of 20 CEWG areas reporting NFLIS data for that year, with small numbers of items identified. Identification of BZP increased to 19 of 21 areas in 2008, and in 2009, BZP was identified in increased numbers in NFLIS forensic laboratories in all of the 21 CEWG areas reporting data (table 1)<sup>12</sup>.
  - Percentages of BZP drug items identified in forensic laboratories rose from a high of 0.14 percent in Detroit in 2007, to 1.6 and 1.7 percent of drug items in Seattle and Washington, DC, respectively, in 2008, to 2.3 and 2.4 percent of drug items in St. Louis and Seattle, respectively, in 2009 (table 1).
  - While BZP ranked in the top 10 drugs identified in forensic laboratories in 2007 in none of the CEWG reporting areas, it was reported in the top 10 drug items in 7 of 21 reporting areas in 2008, and in 11 of 21 areas in 2009. BZP ranked higher in more areas in 2009 than 2008. It ranked 6th in 1 area (Chicago), 7th in 3 areas (Washington, DC, Seattle, and Honolulu), 9th in 1 area (Miami), and 10th in 2 areas (Detroit and Texas) in

<sup>11</sup>Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, [http://www.dea-diversion.usdoj.gov/drugs\\_concern/bzp\\_tmp/bzp\\_tmp.htm](http://www.dea-diversion.usdoj.gov/drugs_concern/bzp_tmp/bzp_tmp.htm).

<sup>12</sup>Data for 22 CEWG areas are reported for 2009 in section III, table 25 for BZP and selected other drug items identified by NFLIS forensic laboratories, whereas table 1 contains only data for CEWG areas with comparable data for 2007 and 2008 as well as 2009.

2008, while in 2009, BZP ranked 5th in 3 areas (Chicago, St. Louis, and Washington, DC), 6th in 1 (Detroit), 7th in 2 (Denver and Seattle), 8th in 3 (Texas, Cincinnati, and Miami), 9th in Honolulu, and 10th in Maine (table 1)<sup>13</sup>.

- The representative from Health Canada reported results from laboratory analyses of seized substances showing that the number of BZP exhibits in Canada increased sevenfold between 2007 and 2008 and doubled in 2009. Similar increases were reported for TFMPP.
- BZP has been detected in tablets sold as MDMA or “ecstasy.” The CEWG Seattle representative reported that BZP and TFMPP remained common adulterants in MDMA tablets, according to chemists at the Washington State Crime Laboratory. According to the representative from South Florida, BZP has been increasingly reported in ecstasy pills, often without MDMA. The Broward County Sheriff’s Office Crime Laboratory reported 65 percent of alleged ecstasy items in early 2010 were identified as BZP.
- A researcher from New Zealand, Dr. Chris Wilkins, reported on the experience with BZP in that country, including findings from survey research examining patterns of use and consequences. BZP was the principal ingredient in a range of recreational stimulants sold legally in New Zealand from 2000 to 2008. Combination BZP/TFMPP pills were common.
  - Concern about the health risks of BZP began to emerge in New Zealand in the mid-2000s. A prospective study of people presenting to

a hospital emergency department with BZP-related problems over a 6-month period in 2005 found that 14 of the 61 patients who presented with BZP problems experienced seizures<sup>14</sup>. A national household survey conducted in 2006 found 15 percent of New Zealanders age 13–45 had used BZP in the past year. While most users reported fairly minor problems from BZP use, such as insomnia (50 percent), some users reported potentially more serious physical problems, such as vomiting (12 percent), inability to urinate (10 percent), chest pains (4 percent), and seizures (0.8 percent). Users also reported a range of psychological problems, including visual hallucinations (9 percent), paranoia (8 percent), and depression (8 percent)<sup>15</sup>.

- BZP was eventually prohibited in New Zealand in 2008, in the face of concerns about health risks, and after industry self-regulation proved ineffective. A national household survey conducted in 2009 showed a decline in past-year prevalence of BZP use among the population age 13–45 from 15 percent in 2006 to 3 percent in 2009. The survey also found that the perceived availability of BZP declined and price increased in 2009, compared with 2006<sup>16</sup>.
- In Europe, BZP was subject to a formal risk assessment by the Scientific Committee of the EMCDDA in 2007 and was subsequently controlled throughout the EU member States in 2008. Occasional seizures of BZP continue to occur.

<sup>13</sup>See footnote 11 above.

<sup>14</sup>Gee, P., Richardson, S., Woltersdorf, W., Moore, G. Toxic effects of BP-based herbal party pills in humans: a prospective study in Christchurch, New Zealand. *New Zealand Medical Journal*; 118(1227):1784, 2005.

<sup>15</sup>Wilkins, C., Sweetser, P., Gilling, M. Patterns of benzylpiperazine/trifluoromethylphenylpiperazine (BZP/TFMPP) party pill use and adverse effects in a population sample in New Zealand. *Drug and Alcohol Review*; 27:633–639, 2008.

<sup>16</sup>Wilkins, C., Sweetser, P., Huckle, T., Asiasiga, L., Griffiths, R. *The impact of the prohibition of benzylpiperazine (BZP) on the use and harm of BZP in New Zealand*. Centre for Social and Health Outcomes Research and Evaluation (SHORE) and Te Ropu Whariki, Massey University, Auckland, New Zealand, 2009.

**Table 1. Number of BZP Drug Items Identified by Forensic Laboratories, in 21 CEWG Areas: 2007–2009<sup>1</sup>**

CEWG AREAS	No. of BZP Drug Items, 2007	Percent-age of All Drug Items, 2007	Top 10 Ranking of BZP, 2007	No. of BZP Drug Items, 2008 <sup>2</sup>	Percent-age of All Drug Items, 2008	Top 10 Ranking of BZP, 2008	Number of BZP Drug Items, 2009	Percent-age of All Drug Items, 2009	Top 10 Ranking of BZP, 2009
Atlanta	5	0.03	--	32	0.3	--	31	0.3	--
Baltimore	NA <sup>3</sup>	NA	NA	63	0.1	--	113	0.2	--
Boston	1	<0.01	--	53	0.3	--	58	0.3	--
Chicago	15	0.02	--	380	0.5	6	1,188	1.5	5
Cincinnati	0	--	--	0	--	--	156	1.2	8
Denver	0	--	--	27	0.3	--	128	1.7	7
Detroit	11	0.14	--	32	0.5	10	144	1.4	6
Honolulu	2	0.07	--	14	0.7	7	8	0.5	9
Los Angeles	4	0.01	--	93	0.2	--	160	0.3	--
Maine	0	--	--	3	0.4	--	14	1.7	10
Maryland	0	--	--	71	0.1	--	126	0.2	--
Miami	5	0.02	--	95	0.3	9	136	0.5	8
Minneapolis/ St. Paul	0	--	--	10	0.2	--	25	0.6	--
New York City	0	--	--	0	--	--	250	0.5	--
Philadelphia	0	--	--	5	0.02	--	51	0.1	--
Phoenix	0	--	--	11	0.2	--	18	0.3	--
St. Louis	3	0.02	--	143	0.8	--	419	2.3	5
San Diego	2	0.01	--	37	0.2	--	52	0.2	--
Seattle	0	--	--	41	1.6	7	62	2.4	7
Texas	0 <sup>4</sup>	--	--	402	0.5	10	1,565	1.5	8
Washington, DC	2	0.05	--	62	1.7	7	63	1.8	5

<sup>1</sup>Data are for calendar years (January–December).

<sup>2</sup>Data for 2008 obtained from DEA were for the top 25 most frequently identified drug items only in contrast to data for 2007 and 2009, which were for all drug items identified in NFLIS forensic laboratories.

<sup>3</sup>Baltimore data for 2007 were for a different geographic unit than for subsequent years and are excluded from the table.

<sup>4</sup>Texas 2007 data received contained only the top 25 most frequently identified substances between January and December of 2007; BZP was not in the top 25 drug items seized in that State that year.

SOURCE: NFLIS, DEA, 2009 data for all areas were received April 24–26, 2010; data for 2008 for all areas were received from DEA on April 14, 2009, while data for 2007 for all areas were received from DEA on May 9, 2008; data are subject to change and may differ according to the date on which the data were queried



## Mephedrone and Synthetic Cathinones

- Mephedrone (4-methylmethcathinone) is a designer drug of the phenethylamine class and shares substantial structural similarities with methcathinone, a Schedule I drug under the CSA. Mephedrone is not approved for medical use in the United States and is not scheduled under the CSA. However, it can be considered an analogue of methcathinone (schedule I substance) under the analogue provision of the CSA. Therefore, law enforcement cases involving mephedrone can be prosecuted under the Federal Analog Act of the CSA<sup>17</sup>.
- Mephedrone was first detected in the EU system in 2007, and its use has expanded since. A Europol-EMCDDA Joint Report on mephedrone was released in May 2010<sup>18</sup>. This report describes the European experience with mephedrone and provides evidence of mephedrone use and associated toxicity increasing in Europe in 2009 and 2010, particularly in the United Kingdom. Mephedrone is available through the Internet and is often advertised as plant food. The representative from the EMCDDA reported that the EU has responded to rising concern over the recreational use of the synthetic drug mephedrone by formally requesting a scientific investigation into the health and social risks of the substance. Mephedrone is just one synthetic cathinone being monitored by the EMCDDA. In 2009, the EU EWS detected a total of four new synthetic cathinones.
- Mephedrone had not been reported in any CEWG area report as of the June 2010 meeting. However, communication from the representative from Texas subsequent to the June meeting indicates availability and use of mephedrone in Austin, based on information from a local research project. The drug was referred to as “meow-meow” (though recognized as mephedrone) and

described as a white powder in a large capsule. Self-reported effects include feeling jittery and sick.

## Other Drugs and Drug Abuse Patterns/Issues

Polysubstance abuse, noted in previous CEWG reporting periods, persisted across all CEWG areas, and high levels of alcohol abuse continued to be noted for several CEWG areas.

### TFMPP

- TFMPP is a synthetic substance with no accepted medical use in the United States. Often taken in combination with BZP as a substitute for MDMA, TFMPP is currently an uncontrolled substance. It is, however, causing growing concern among representatives in several CEWG areas, including Atlanta and Texas. Because it is not a controlled substance, it may frequently not be reported, a dynamic that would influence indicator data.
- The identification of TFMPP in 2009 NFLIS data was localized to 8 of 22 areas: Texas, Atlanta, Chicago, Washington, DC, Honolulu, New York City, San Francisco, and Philadelphia (section III, table 25, footnote 1). This was an increase from its presence in NFLIS data for two areas (Atlanta and Washington, DC) in 2008, and one area (Atlanta) in 2007. In 2009 forensic laboratory data, TFMPP ranked seventh and ninth in frequency among drug items identified in Washington, DC, and Atlanta, respectively (table 2). In 2008, it ranked eighth in frequency among drug items identified in these same two areas. It should be noted that since TFMPP is not a controlled substance, it may not be reported to NFLIS by forensic laboratories in all areas.
- The representative from Health Canada reported that results from laboratory analyses of drug

<sup>17</sup>Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, [http://www.deadiversion.usdoj.gov/drugs\\_concern/mephedrone.htm](http://www.deadiversion.usdoj.gov/drugs_concern/mephedrone.htm).

<sup>18</sup>Europol-EMCDDA Joint Report on Mephedrone, [http://www.emcdda.europa.eu/attachements.cfm/att\\_102496\\_EN\\_Europol-EMCDDA\\_Joint\\_Report\\_Mephedrone.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_102496_EN_Europol-EMCDDA_Joint_Report_Mephedrone.pdf).



exhibits seized in Canada revealed that the number of exhibits of BZP and TFMPP increased sevenfold between 2007 and 2008 and doubled in 2009.

### **Carisoprodol**

- Carisoprodol is a muscle relaxant and central nervous system depressant that is available by prescription as Soma®. It is not controlled on the Federal level (although control as a Schedule IV substance has been proposed by the DEA), but several States have scheduled Soma® as a controlled substance.
- Increases in indicators of carisoprodol abuse in Texas, noted in recent reporting periods, continued into 2009. The Texas area representative reported that carisoprodol was one of the most popular drugs in the illicit drug market in the Dallas/Fort Worth area. It is part of the combination with hydrocodone and alprazolam that is known as the “Houston Cocktail” or “Holy Trinity,” according to the area representative. Texas poison control centers confirmed that exposure cases of intentional misuse or abuse of carisoprodol increased from 83 in 1998 to 428 in 2009. Elsewhere in the West, in Phoenix, the number of drug items identified as carisoprodol by NFLIS increased from 47 in 2008 to 63 in 2009.
- Carisoprodol was identified among drug items seized and analyzed in 15 of 22 reporting areas in 2009; it was not identified in 7 areas (Baltimore, Maine, Maryland, New York City, Philadelphia, Seattle, and Washington, DC) (table 25). In 2009, drug items containing carisoprodol represented 1 percent of identified NFLIS drug items in Texas and Phoenix, and they ranked 9th in Texas and Phoenix and 10th in Atlanta among the 10 most frequently identified items from 22 CEWG areas (table 2). Carisoprodol ranked in the top 10 drugs identified in these same three areas in 2007 (ranking 8th in each of the three), and in 2008, it ranked 8th in the top 10 drugs in Texas and Phoenix, and 10th in Atlanta and Los Angeles.

### **Levamisole**

- Several CEWG area representatives continued to report levamisole, a veterinary drug used to control parasites in livestock, as a cutting agent used with cocaine. The drug is not available for human use in the United States, and its abuse can lead to an autoimmune disorder, agranulocytosis (or neutropenia), in which there is a marked decrease in white blood cells. Increases in 2009 in the use of levamisole as an adulterant in cocaine were reported by the area representatives from Maine, Philadelphia, Washington, DC, Miami/South Florida, Cincinnati, Detroit, Minneapolis/St. Paul, and Seattle (see section on cocaine for details). Across the border in Canada, the representative from Vancouver reported sporadic cases of neutropenia related to crack cocaine adulterated with levamisole in Alberta and British Columbia.

### **Salvia Divinorum**

- *Salvia divinorum* is a perennial herb that produces short-acting hallucinogenic effects when chewed, smoked, or brewed in tea. It is available on the Internet and is favored by adolescents. It is not currently federally controlled, although some States control it as a Schedule I drug. Because it is difficult for poison control centers to identify, its use is often difficult to detect and monitor.
- The area representative from Minneapolis/St. Paul reported that in Minnesota, where *Salvia* is often used by adolescents and young adults, the sale or possession of *Salvia divinorum* or salvinorin A (from the plant) will become a gross misdemeanor on August 1, 2010.

### **Psilocin/Psilocybin**

- Psilocin/psilocybin ranked 9th in Denver and 10th in Minneapolis/St. Paul in the 2009 NFLIS data (table 2). In 2008, psilocin ranked 8th in Denver and 10th in Maine, while in 2007, it ranked 10th in Los Angeles among the 10 most frequently identified drug items in the NFLIS system. Psilocin/psilocybin was reported among

drug items seized and identified in forensic laboratories in 20 of 22 CEWG areas in 2009; the exceptions were Honolulu and Washington, DC (section III, table 25).

### **Foxy Methoxy**

- Foxy Methoxy (5-Methoxy-N, N-Diisopropyltryptamine, or 5-MeO-DIPT), a synthetic substance abused for its hallucinogenic effects, is illegal in the United States and is controlled as a Schedule I substance under the Controlled Substance Act. Foxy Methoxy was not detected in NFLIS data for CEWG areas in 2009, and it was not mentioned as a drug of concern in any CEWG area.
- Foxy Methoxy drug items were identified in two CEWG areas, which were Miami, with four items containing Foxy reported, and Denver, with two items in 2009 (section III, table 25, footnote 1). Foxy Methoxy was identified in drug items in 1 CEWG area in 2008, namely Denver, with 19 items containing this substance identified that year. No areas reported Foxy Methoxy in 2007 NFLIS data.

### **Quetiapine**

- Quetiapine, an antipsychotic drug marketed as Seroquel®, appeared in NFLIS data in Boston in 2007 (15 drug items identified), and in Boston and Texas in 2008 (70 and 164 samples identified, respectively). In 2009, quetiapine reappeared in both Boston (ranking 14th with 91 samples identified) and Texas data (ranking 17th with 260 samples identified).
- In Philadelphia, antipsychotics have not been identified as “street drugs,” according to the area representative. However, they have been detected in medical examiner toxicology results. The three drugs that were most frequently detected in decedents in this area from 2005 through 2009 were quetiapine ( $n=156$ ), olanzapine ( $n=103$ ), and clozapine ( $n=27$ ).
- The Maine area representative noted that quetiapine has emerged among recent causes of drug-related deaths, with such deaths rising

from 8 percent in 2008 to 9 percent in 2009 (figure 10).

### **Khat (Cathinone, Cathine)**

- Khat, a plant indigenous to East Africa and the Arabian Peninsula and used for its stimulant effects in East Africa and the Middle East, maintained a hidden presence within the Somali immigrant community in the Minneapolis/St. Paul Twin Cities area, according to the CEWG area representative. Its active ingredients, cathinone and cathine, are controlled substances in the United States. Cathinone, a Schedule I drug, is present only in the fresh leaves of the flowering plant and converts to the considerably less potent cathine in approximately 48 hours. Users chew the leaves, smoke it, or brew it in tea.

### **HIV/AIDS Related to Drug Abuse**

Drug use contributes to human immunodeficiency virus (HIV) transmission both directly through sharing injection equipment and indirectly through its influence on risky sexual behaviors. The CEWG continues to monitor trends in injection drug use as important for understanding the consequences of drug use, including HIV infection and acquired immunodeficiency syndrome (AIDS).

- *Transmission of or exposure to HIV and AIDS through injection drug use has steadily decreased in several CEWG areas in all regions of the country through 2008, as reported by area representatives from Philadelphia, Atlanta, Chicago, Phoenix, and Texas, and through 2009 in San Francisco, according to the area representative. Relatively stable proportions of injection drug users (IDUs) living with HIV and AIDS were reported by the New York City representative for 2008 and by the Miami/South Florida area representative for 2009. An increase in exposure to HIV through injection drug use, however, was reported for the first quarter of FY 2010 by the area representative from Detroit. In addition, an increase in newly diagnosed AIDS cases with injection*

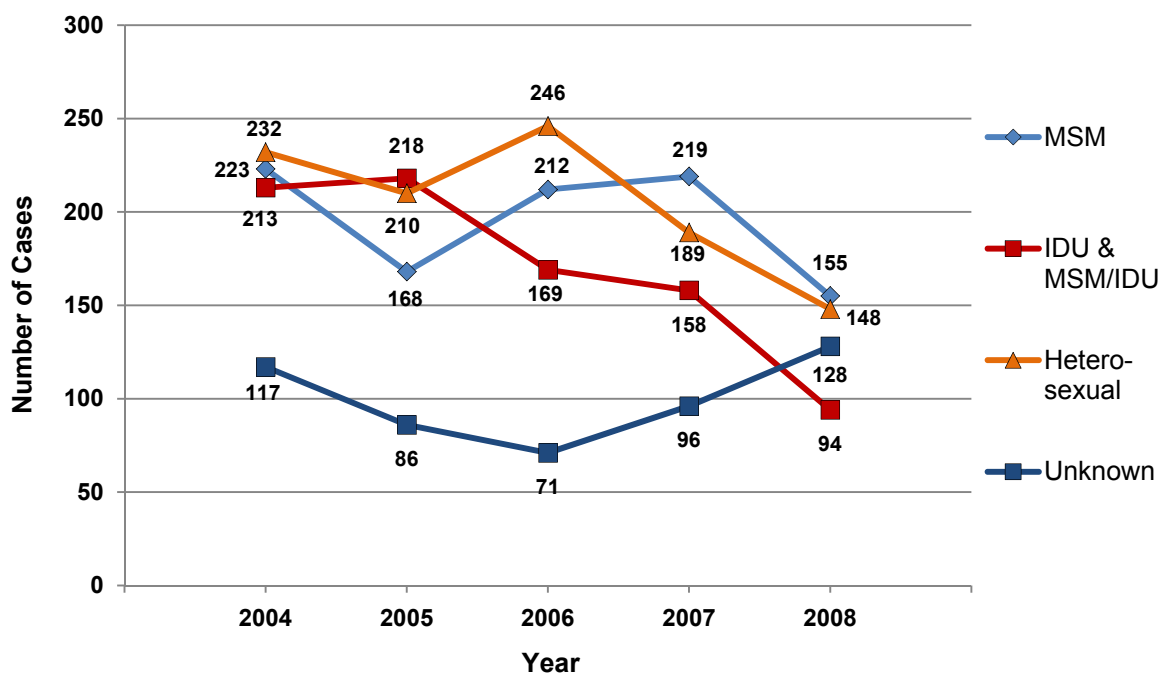
*drug use as the exposure category, from 6 percent in 2008 to 14 percent in 2009, was reported in Colorado by the Denver area representative.*

- The proportion of HIV diagnoses involving IDUs and associated with sharing infected needles was reported to be declining in the Philadelphia area. In 2008, 11.7 percent of HIV diagnoses were related to injection drug use, down from 16.9 percent in 2007 and 19.3 percent in 2006. Cumulative totals from November 1981 to December 2008 showed 33.5 percent of total cases involved injection drug use as the exposure category. Similarly, as of December 31, 2008, 16.8 percent of cumulative AIDS cases involved injection drug use, down from 21.9 percent in 2007 and 23.0 percent in 2006.
- The Baltimore/Maryland/Washington, DC, area representative reported that newly diagnosed IDU and men who have sex with men (MSM)/IDU AIDS cases in the Washington, DC, area decreased from 218 in 2005 to 94

in 2008 (figure 21). HIV cases among IDUs in Maryland also decreased steadily from 44.2 percent in 2001 to 21.8 percent in 2008. In Atlanta, 15 percent of AIDS exposures were among IDUs or MSM/IDUs, a decrease from 2007, according to the area representative.

- Of the 982 new cases of HIV (not AIDS) diagnosed in 2008 in Chicago, only 12 percent were attributed to injection drug use, well below the 26 percent reported in 2000. Elsewhere in the Midwest, the Cincinnati and St. Louis area representatives reported relatively low proportions of injection drug use-involved HIV cases. Only 4.4 percent of the transmissions of HIV in the State of Ohio in 2008 were reported to be through injection drug use. Data from Hamilton County (Cincinnati) showed that approximately 7 percent of the cases reported in that county involved injection drug use transmission in 2008. In the St. Louis metropolitan area, 4.3 percent of the cases reported as living with HIV, and 6.5

**Figure 21. New AIDS Cases Diagnosed in Washington, DC: 2004–2008**



SOURCE: Washington, DC, Department of Health, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB Epidemiology Annual Report Update 2009*, as reported by Erin Artigiani at the June 2010 CEWG meeting

percent of cases reported as living with AIDS, involved IDUs in 2009; this trend was stable from the previous year.

- In Arizona, 5-year emergent HIV/AIDS rates (per 100,000 population per year) related to injection drug use have declined slowly but steadily over the past several years, according to the Phoenix area representative. These rates decreased from 207.9 per 100,000 in 2003–2007 to 181.8 per 100,000 in 2004–2008. Similarly, the proportions of HIV cases involving IDUs or MSM/IDUs in Texas have decreased over time. IDU cases have declined from 20 percent in 2000 to 10 percent in 2008, and MSM/IDU cases declined from 8 percent in 2000 to 3 percent in 2008 in that State.
- As of the end of 2008, the proportion of people living with HIV and AIDS in New York City with a history of injection drug use remained stable at approximately 20 percent. The area representative from Miami/South Florida reported relatively stable and slightly decreasing proportions of cumulative AIDS cases who were IDUs or MSM/IDUs in 2009. In Miami/Dade County, 15.9 percent of AIDS cases were IDUs, and 3.9 percent were MSM/IDUs, compared with 16.4 and 4.1 percent, respectively, in 2008. In Broward County in 2009, 11.5 percent of cumulative AIDS cases were IDUs, compared with 12 percent in 2008, while the same percentage (3.9 percent) were MSM/IDUs in 2008 and 2009.
- Although the percentage of newly diagnosed HIV/AIDS cases with a history of injection drug use had been decreasing in Michigan in recent years (reaching a low of 5 percent in 2009), the proportion increased in early 2010 to 15 percent. According to the area representative, this change may be due to more testing, especially at substance abuse treatment programs and the needle exchange program. While the proportion of newly diagnosed HIV cases attributed to injection drug use has stayed fairly stable (at around 3–4 percent) in Colorado since 2007, the proportion of newly diagnosed AIDS cases attributed to injection drug

use increased from 6 percent in 2008 to 14 percent in 2009.

- Some area representatives reported differences in exposure categories for HIV and AIDS among gender and race/ethnicity groups, including Los Angeles and Minneapolis/St. Paul. In Los Angeles County, the percentage of AIDS cases that were either IDUs or MSM/IDUs was stable for males from 2008 to 2009, at 8 percent. However, the percentage of IDU AIDS cases that were female increased from 10 percent in 2008 to 13 percent in 2009. The Minneapolis/St. Paul area representative reported on racial differences in exposure categories. Among the male cases for whom injection drug use was identified as a risk factor, 17 percent were African-American, 12 percent were Hispanic, and 13 percent were American Indian. The comparable percentages among Asian, White, and African-born males were 4, 3, and 1 percent, respectively. Injection drug use was reported as a primary mode of exposure in the Twin Cities of Minneapolis/St. Paul in 22 percent of American Indian females, 18 percent of African-American females, 17 percent of White females, 13 percent of Hispanic females, and 3 percent of Asian females.

## International Drug Abuse Patterns/Issues

### Europe

Drug abuse trends in Europe were updated for the CEWG by a returning representative from the EMCDDA, the agency that collects drug-related information from 27 EU member states, Croatia, Turkey, and Norway.

- Cocaine remained the second most commonly consumed illicit drug in the EU. However, cocaine indicators were not consistent across countries. High prevalence rates were reported in some countries (Spain, the United Kingdom, Italy, Ireland, the Netherlands, and Denmark), while elsewhere (such as Eastern Europe) use was reported as low.



- Heroin indicators, which had decreased yearly until 2004, were stable in the EU and EMCDDA countries in 2008. Of note, although data on drug-related deaths and treatment entries still pointed to an aging population of heroin consumers, some countries reported pockets of younger heroin users.
- There has been a decline in MDMA indicators in EMCDDA countries, according to the EMCDDA representative, and increases in piperazines in tablets sold as ecstasy were reported.
- Drug law offenses for cannabis continued to rise, and new approaches to domestic cannabis production detection were being developed. While cannabis levels were on the rise in Eastern European countries, surveys of both youth and the general population suggested that overall levels of cannabis use were falling in younger cohorts and in higher-prevalence countries.

## Canada

- According to the representative from Health Canada, cannabis continued to be the dominant illicit drug in Canada in 2009, based both on self-reported past-year use from surveys and on laboratory analysis of exhibits from seized substances. The majority of drug exhibits analyzed from substances seized by police and border services in Canada continued to be cannabis, followed by cocaine. However, the number of cocaine exhibits analyzed continued to decrease in 2009 (by 23 percent since 2007).
- Cross-border issues in 2008 were presented by the Health Canada representative based on information from the Royal Canadian Mounted Police. Cannabis/marijuana and synthetic drugs were being smuggled to the United States across the border from Canada, and cocaine and firearms were reported as smuggled into Canada from the United States. Smuggling MDMA from Canada to the United States continued as a law enforcement issue. Some methamphetamine continued to move across the United States–Canada border in both northbound and southbound directions in this reporting period.

## Vancouver

- Of substances seized and analyzed by the Health Canada Drug Analysis Service in Vancouver and British Columbia, cannabis/marijuana remained the most frequently reported drug item among exhibits. The increase there in cocaine exhibits continued into 2008, while heroin indicators remained stable in that same time period. Deaths related to illicit drugs in British Columbia declined from 8.1 per 100,000 population in 2002 to 6.5 in 2008. At the same time, however, hospitalizations related to illicit drugs increased from 82 to 109 per 100,000.

## Mexico

- Representatives from Mexico's National Institute of Psychiatry Ramón de la Fuente Muñiz reported on the results in that country of the National Household Survey of Addictions in 2008 (NHSA 2008) and findings of school population surveys of 7th to 12th grade students in Mexico's States. According to the NHSA 2008, alcohol was the main drug abuse problem across Mexico. Results also showed that cocaine use prevalence increased slightly, from 1.4 percent of the population in 2002 to 2.4 percent in 2008; marijuana also increased in that period. Although methamphetamine use among the household population was relatively low, methamphetamine use increased from 0.1 percent in 2002 to 0.8 percent in 2008.
- The representatives from Mexico reported that drug use overall had increased in their country in 2008, compared with the previous two decades, and cocaine and marijuana have shown the largest increases.
- Drug dependence indicators were reported by the Mexican representatives as highest in Mexico along the northern United States border and in Baja California on the Pacific coast, according to the NHSA 2008. The Mexican States of Chihuahua and Baja California had the highest prevalence of drug dependence. Border trends in Mexico were still lower than the prevalence reported across the border in the United States.



## The Netherlands

- The representative from the Trimbos Institute in the Netherlands reported that cannabis continued to be the most commonly consumed illicit drug in the Netherlands. Use prevalence there was stable in 2009, compared with 2008, but there were increases in treatment admissions related to cannabis and in hospital admissions related to cannabis abuse and dependence. The Netherlands representative noted that these increases may be due to improved treatment availability or a growing awareness of the addictive properties of cannabis. Ecstasy remained the most popular club drug in the Netherlands based on the EMCDDA's 2009 National Prevalence Survey. However, the proportion of ecstasy samples containing MDMA decreased from 91 percent in 2007, to 82 percent in 2008, to only 58 percent in 2009. The most common adulterants in ecstasy pills were meta-chlorophenylpiperazine (mCPP) (21 percent in 2009) and mephedrone. Cocaine (particularly powder for snorting) remained the second most popular club drug in the Netherlands among young adults, but its use had stabilized based on treatment demand data. Market indicators showed a strong increase in the percentage of adulterants in cocaine, especially levamisole and phenacetin. (An analgesic once widely used,

phenacetin's use has declined in the United States because of its adverse effects, which include serious kidney damage with chronic use at high doses.) All indicators for opiates/opioids were decreasing in the Netherlands, and the population of problem opiate users was reported to be aging based on data from addiction treatment services. An increase in the popularity of GHB in some subpopulations in the Netherlands indicated in drug treatment admissions and hospital emergency department visits was reported by the representative as an issue of growing concern. There was a fourfold increase in GHB-related hospital emergencies between 2003 and 2008 (with an estimated 980 cases in 2008).

- According to the Netherlands representative, both policy and legislation in the Netherlands make a distinction between hard drugs and cannabis. However, a tobacco smoking ban implemented in July 2008 appeared to have affected the popularity of coffee shops (and related cannabis use there). Other recently implemented Dutch drug policies that were related to stabilizing or decreasing indicators for some drugs included the following: all hallucinogenic mushrooms were placed on Schedule II of the Opium Act in December 2008; and in August 2009, BZP became a Schedule II drug under the Opium Act.

Table 2. NFLIS Top 10 Drug Items Analyzed by CEWG Area and Rank (Based on Frequency): January–December 2009<sup>1</sup>

CEWG Areas	Cocaine/ Crack	Heroin	Oxy- codone	Hydro- codone	Alpraz- olam	Clonaz- epam	Metham- phetamine	Cannabis/ THC	MDMA	Phency- clidine (PCP)	Other Drugs
SOUTHERN REGION											
Atlanta	1	6	4	5	3	--	2	7	8	--	1-(3-Trifluoromethylphenyl)piperazine=9; Carisoprodol=10
Baltimore	2	3	4	10	6	7	--	1	9	--	Buprenorphine=5; Methadone=8
Maryland	2	3	4	--	6	7	--	1	8	10	Buprenorphine=5; Methadone=9
Miami	1	3	7	10	4	--	9	2	6	--	Hallucinogen (Nonspecified)=5; 1-Benzylpiperazine=8
Washington, DC	1	3	9	--	--	--	6	2	10	4	1-(3-Trifluoromethylphenyl)piperazine=7; Buprenorphine=7
NORTHEASTERN REGION											
Boston	1	3	4	8	7	5	--	2	9	--	Buprenorphine=6; Amphetamine=10
Maine	1	2	4	8	--	--	5	3	6	--	Buprenorphine=7; Methadone=9; 1-Benzylpiperazine=10
New York City	1	3	5	9	4	--	--	2	6	8	Methadone=7; Buprenorphine=10
Philadelphia	2	3	4	9	5	8	--	1	--	6	Codeine=7; Buprenorphine=10
MIDWESTERN REGION											
Chicago	2	3	--	6	8	--	7	1	4	9	1-Benzylpiperazine=5; Acetaminophen=10
Cincinnati	2	3	4	5	6	10	9	1	7	--	1-Benzylpiperazine=8
Detroit	2	3	8	4	7	--	9	1	5	--	1-Benzylpiperazine=6; Codeine=10
Minneapolis/ St. Paul	3	5	6	7	9	--	2	1	4	--	Amphetamine=8; Cathinone=10; Psilocybin/Psilocyn=10
St. Louis	2	3	8	6	7	--	4	1	9	--	1-Benzylpiperazine=5; Pseudoephedrine=10
WESTERN REGION											
Denver	1	4	6	8	10	--	3	2	5	--	1-Benzylpiperazine=7; Psilocin=9
Honolulu	3	4	7	--	9	--	1	2	5	--	Acetaminophen=6; Morphine=8; 1-Benzylpiperazine=9
Los Angeles	2	4	10	6	8	--	3	1	5	7	Codeine=9
Phoenix	3	4	5	6	7	10	2	1	8	--	Carisoprodol=9
San Diego	3	4	7	5	8	10	2	1	6	--	Diazepam=9
San Francisco <sup>1</sup>	2	4	7	6	--	10	3	1	5	--	Methadone=8; Morphine=9
Seattle	2	4	5	9	10	--	3	1	6	--	1-Benzylpiperazine=7; Buprenorphine=8
Texas	2	6	--	5	4	10	3	1	7	--	1-Benzylpiperazine=8; Carisoprodol=9

<sup>1</sup>San Francisco data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

Note: Washington, DC, has a tie for 7th, Honolulu has a tie for 9th, and Minneapolis/St. Paul has a tie for 10th most frequently identified drug.

SOURCE: NFLIS, DEA, data for Atlanta, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; see appendix tables 2.1–2.22; data are subject to change and may differ according to the date on which they were queried

**Table 3. Top-Ranked Primary Drugs as a Percentage of Total Treatment Admissions, Including Primary Alcohol Admissions, in 22 CEWG Areas<sup>1</sup>, by Region and Ranking: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas	Alcohol	Cocaine/ Crack	Heroin	Opiates/ Opioids Other Than Heroin	Metham- phetamine	Marijuana/ Cannabis	Other Drugs
FY 2009							
Cincinnati	1	5	3 <sup>4</sup>	-- <sup>4</sup>	6 <sup>5</sup>	2	4
San Francisco	1	2	3	NR <sup>6</sup>	4	5	6
CY 2009							
SOUTHERN REGION							
Atlanta	1	3	6	4	5	2	7
Baltimore	2	3	1	5	7	4	6
Maryland	1	4	2	5	7	3	6
Broward County	2	4	6	5	7	1	3
Miami/Dade County	3	2	5	6	7	1	4
NORTHEASTERN REGION							
Boston	2	3	1	5	7	4	6
Maine	1	6	4	2	7	3	5
New York City	1	4	2	6	7	3	5
Philadelphia	2	3	4	6	7	1	5
MIDWESTERN REGION							
Detroit	2	3	1	5	7	4	6
Minneapolis/St. Paul	1	5	4	3	6	2	7
St. Louis	1	4	2	5	6	3	7
WESTERN REGION							
Colorado	1	4	5	6	3	2	7
Denver	1	4	5	6	3	2	7
Hawaii	3	5	6	NR <sup>6</sup>	1 <sup>5</sup>	2	4
Los Angeles	2	5	3	6	4	1	7
Phoenix <sup>7</sup>	1	5	3	6	2	4	7
San Diego	2	5	4	6	1	3	7
Seattle	1	4	3	6	5	2	7
Texas	1	3	4	6	5 <sup>5</sup>	2	7

<sup>1</sup>CEWG areas not included in the table due to lack of availability of treatment admissions data for the reporting period are Chicago and Washington, DC.

<sup>2</sup>Data are for the fiscal year 2009: July 2008–June 2009.

<sup>3</sup>Data are for the calendar year 2009: January–December 2009.

<sup>4</sup>Heroin and other opiates are grouped together in Cincinnati treatment data.

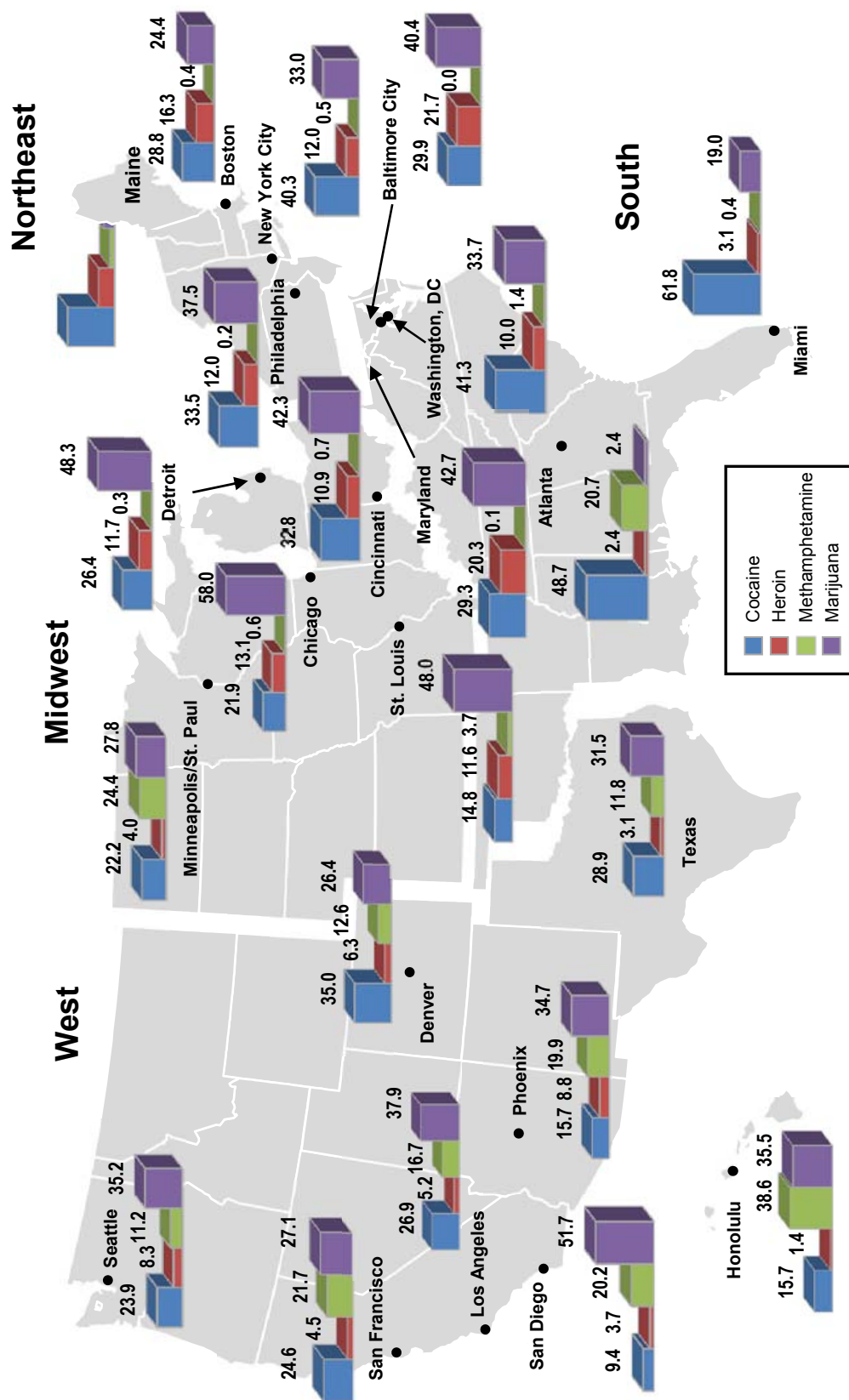
<sup>5</sup>Methamphetamine and amphetamine are grouped together in Texas treatment data. Methamphetamine, amphetamine, and MDMA are grouped together in Cincinnati treatment data. Methamphetamine and stimulants are grouped together in Hawaii treatment data.

<sup>6</sup>NR=Not reported by the CEWG area representative.

<sup>7</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports

**Figure 22. Percentages of Cocaine, Heroin, Methamphetamine, and Marijuana Items Analyzed by Forensic Laboratories in 22 CEWG Areas in Four U.S. Regions, Each as a Percentage of Total Items Analyzed: CY 2009<sup>1</sup>**



<sup>1</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009 (note that drug item counts for San Francisco should not be compared with counts from previous years); see appendix tables 2.1–2.22. Data are subject to change; data queried on different dates may reflect differences in the timing of data analysis and reporting. SOURCE: NFLIS, DEA; data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010

## Section III. Across CEWG Areas: Treatment Admissions and Forensic Laboratory Analysis Data

### Cocaine/Crack

- Treatment admissions data for 2009 revealed that treatment admissions for primary cocaine/crack, as a percentage of total drug treatment admissions, including primary alcohol admissions, ranked first in frequency in none of the 22 reporting CEWG areas, although it ranked second in Miami/Dade County and San Francisco (section II, table 3). In 2009, Miami/Dade County had the highest proportion of primary cocaine admissions, including primary alcohol admissions among 22 reporting CEWG areas, at approximately 28 percent, followed by Philadelphia and San Francisco, at approximately 21 percent (table 4). The most common route of administration in all reporting areas was smoking (table 5).
- Over the 5-year period from 2005 through 2009, declines were noted in 12 of 14 areas reporting data. Atlanta, Minneapolis/St. Paul, and St. Louis saw the largest declines in cocaine admissions, excluding primary alcohol admissions, at 19.5, 13.3, and 12.4 percentage points, respectively (table 7). Between 2008 and 2009, all 14 CEWG reporting areas showed declines in primary cocaine admissions, with the largest decreases observed in Seattle and Minneapolis/St. Paul, at approximately 8 percentage points each (table 7).
- Cocaine was the drug most frequently identified by forensic laboratories in 7 of 22 reporting CEWG areas. Based on forensic laboratory analysis of drug items identified in 2009, cocaine/crack ranked first in three of five areas in the southern region (Miami, Atlanta, and Washington, DC); three of four areas in the northeastern region (Boston, New York City, and Maine); and one of eight areas in the western region (Denver). Cocaine ranked first in none of the five CEWG areas in the midwestern region in frequency of drug items identified. Cocaine ranked second in drug items identified in 2009 in 11 of 22 CEWG areas (section II, table 2; appendix table 2). Miami/Dade had the highest percentage of drug items containing cocaine identified in NFLIS forensic laboratories in 2009, at approximately 62 percent, followed by Atlanta, at approximately 49 percent (figure 23; section II, figure 22).

### Treatment Admissions Data on Cocaine/Crack

Table 4 presents the most recent data from 22 CEWG areas on primary cocaine treatment admissions as a proportion of total admissions, including those for alcohol (see also appendix table 1). The 2009 reporting period is CY 2009, January

through December 2009, for all but two areas. For Cincinnati and San Francisco, FY 2009 data cover the period from July 2008 through June 2009.

Miami/Dade County had the highest percentage (28.1 percent) of primary cocaine admissions, followed distantly by Philadelphia (21.4 percent) and San Francisco (21.1 percent). The lowest proportions of primary cocaine treatment admissions,



**Table 4. Primary Cocaine Treatment Admissions in 22 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions<sup>1</sup>: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas	Primary Cocaine Admissions	Total Admissions with Primary Alcohol Admissions Excluded <sup>4</sup>		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2009					
Cincinnati	673	3,704	18.2	5,480	12.3
San Francisco	6,797	22,652	30.0	32,141	21.1
CY 2009					
Atlanta	1,465	4,830	30.3	9,333	15.7
Baltimore	2,409	14,478	16.6	17,397	13.8
Boston	1,343	13,392	10.0	19,638	6.8
Colorado	2,660	16,470	16.2	28,510	9.3
Denver	1,333	7,350	18.1	11,947	11.2
Detroit	1,806	6,643	27.2	9,368	19.3
Hawaii	335	7,229	4.6	8,930	3.8
Los Angeles	6,690	40,916	16.4	53,036	12.6
Maine	575	8,017	7.2	14,498	4.0
Maryland	6,737	40,638	16.6	60,404	11.2
Broward County	769	4,424	17.4	5,678	13.5
Miami/Dade County	1,557	4,253	36.6	5,542	28.1
Minneapolis/St. Paul	1,317	9,961	13.2	20,645	6.4
New York City	13,744	59,980	22.9	83,401	16.5
Philadelphia	3,182	11,375	28.0	14,864	21.4
Phoenix <sup>5</sup>	236	2,906	8.1	4,481	5.3
St. Louis	1,585	7,499	21.1	11,677	13.6
San Diego	763	11,284	6.8	14,258	5.4
Seattle	1,443	7,560	19.1	12,986	11.1
Texas	16,234	65,784	24.7	91,072	17.8

<sup>1</sup>More information on these data is available in the footnotes and notes for appendix table 1.<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for calendar year 2009: January–December 2009.<sup>4</sup>For comparability with past data, percentages of primary cocaine admissions are obtained from admissions with primary alcohol admissions excluded.<sup>5</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports

including primary alcohol admissions, were observed for Hawaii (3.8 percent) and Maine (4.0 percent) (table 4).

Based on total 2009 treatment admissions, including those for primary alcohol problems, cocaine ranked first in none of the 22 CEWG reporting areas. It ranked second in Miami/Dade County and San Francisco and third in 6 of the 22 reporting CEWG areas: Atlanta, Baltimore, Boston, Philadelphia, Detroit, and Texas (section II, table 3).

#### **Route of Administration of Cocaine.**

Data from 18 CEWG areas indicate that smoking<sup>19</sup> was the most common mode of cocaine administration among primary cocaine treatment admissions in 2009 (table 5). The range is from approximately 48 percent in Maine to more than 96 percent in Detroit. After Detroit (96.1 percent), the highest percentages of smoking cocaine were reported in St. Louis (88.8 percent), Baltimore (87.6 percent), and Los Angeles (85.1 percent). Inhaling or sniffing cocaine was the primary route of administration in approximately 34–38 percent of cocaine admissions in Broward County, New York City, Denver, and Miami/Dade County. The lowest proportions reporting inhaling or sniffing cocaine as the primary administration route were in Detroit, at 3.3 percent. Across the CEWG areas reporting data on mode of administration of cocaine, the proportions of cocaine admissions who reported injecting the drug as the primary route tended to be low, with by far the highest proportions being in Maine, at 16.0 percent, followed by Boston (at approximately 8.5 percent) (table 5).

#### **Gender of Cocaine/Crack Admissions.**

Across all but one reporting CEWG area in 2009, the majority of primary cocaine admissions were male (table 6). The exception was Atlanta, where 46.3 percent of primary cocaine admissions were male. The highest proportions of male cocaine admissions were in Philadelphia (70.8 percent) and New York City (68.7 percent), while the

lowest percentages were in Texas (50.7 percent) and Atlanta (46.3 percent) (table 6).

#### **Age of Cocaine/Crack Admissions.**

In 19 of 20 reporting CEWG areas in 2009, at least one-half of the primary cocaine treatment admissions were age 35 or older (or 36 and older in Florida and 40 and older in Seattle), with the largest proportions reported in Baltimore (84.7 percent) and Detroit (84.3 percent) (table 6). In Maine, proportions of older cocaine admissions were lowest, at 44.3 percent. The highest percentages of cocaine treatment admissions age 25 and younger were in Maine (20.0 percent) and Colorado and Miami/Dade (approximately 15 percent each) (table 6).

#### **Changes in Cocaine/Crack Admissions, 2005–2009**

Table 7 shows changes in primary cocaine/crack treatment admissions as a percentage of total admissions, excluding primary alcohol admissions, between 2005 and 2009. Declines were noted in all but 2 of 14 areas reporting data, specifically Baltimore and Hawaii, where increases of less than 1 percentage point are shown. Decreases from 2005 to 2009 in the proportion of primary cocaine admissions were highest in Atlanta (19.5 percentage points), Minneapolis/St. Paul (13.3 percentage points), and St. Louis (12.4 percentage points), followed by Texas and Phoenix, with percentage-point declines of 9.4 and 8.0, respectively. Decreases of approximately 5–7.5 percentage points were observed for Maine, Detroit, Seattle, and New York City over the 5-year period (table 7). Other areas experiencing moderate (1.4–4.1 percentage points) declines in the proportion of primary cocaine treatment admissions were Denver, Los Angeles, and San Diego.

Declines in cocaine treatment admission proportions were reported in all 14 CEWG areas for which comparable data were available from the

<sup>19</sup>SAMHSA's Treatment Episode Data Set (TEDS) report (2003) notes that, "Smoked cocaine primarily represents crack or rock cocaine, but can also include cocaine hydrochloride (powder cocaine) when it is free-based." TEDS does not separately report crack and cocaine; however, several CEWG sites have different codes for crack compared with cocaine, and area representatives may separate these out in their reporting.

**Table 5. Primary Route of Administration of Cocaine Among Treatment Admissions in 18 CEWG Areas as a Percentage<sup>1</sup> of Primary Cocaine Treatment Admissions: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas <sup>4</sup>	Smoked		Inhaled		Injected		Oral/Other/ Unknown		Total N
	#	%	#	%	#	%	#	%	
CY 2009									
Atlanta	1,132	77.3	276	18.8	22	1.5	35	2.4	1,465
Baltimore	2,111	87.6	146	6.1	138	5.7	14	0.6	2,409
Boston	915	68.1	288	21.4	114	8.5	26	1.9	1,343
Colorado	1,646	61.9	806	30.3	168	6.3	40	1.5	2,660
Denver	782	58.7	475	35.6	60	4.5	16	1.2	1,333
Detroit	1,735	96.1	59	3.3	0	0.0	12	0.7	1,806
Los Angeles	5,693	85.1	805	12.0	45	0.7	147	2.2	6,690
Maine	278	48.3	181	31.5	92	16.0	24	4.2	575
Maryland	5,509	81.8	874	13.0	277	4.1	77	1.1	6,737
Broward County	448	58.3	294	38.2	5	0.7	22	2.9	769
Miami/Dade County	976	62.7	532	34.2	6	0.4	43	2.8	1,557
Minneapolis/ St. Paul	1,030	78.2	250	19.0	19	1.4	18	1.4	1,317
New York City	8,390	61.0	4,927	35.8	205	1.5	222	1.6	13,744
Philadelphia	2,415	75.9	295	9.3	112	3.5	360	11.3	3,182
Phoenix <sup>5</sup>	188	79.7	37	15.7	5	2.1	6	2.5	236
St. Louis	1,407	88.8	111	7.0	23	1.5	44	2.8	1,585
San Diego	603	79.0	135	17.7	15	2.0	10	1.3	763
Texas	9,785	60.3	5,127	31.6	629	3.9	693	4.3	16,234

<sup>1</sup>Percentages may not sum to 100 due to rounding.<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for calendar year 2009: January–December 2009.<sup>4</sup>No data were available for Cincinnati, Hawaii, San Francisco, and Seattle.<sup>5</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports

**Table 6. Demographic Characteristics of Primary Cocaine Treatment Admissions in 20 CEWG Areas as a Percentage<sup>1</sup>: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas	Gender <sup>4</sup>		Age Group	
	Percent Male	Percent Female	Percent 25 and Younger	Percent 35 or Older
FY 2009				
Cincinnati	51.4	48.6	11.1	72.4
CY 2009				
Atlanta	46.3	53.7	7.6	72.3
Baltimore	51.6	48.4	4.3	84.7
Boston	60.2	39.3	10.3	67.5
Colorado	58.5	41.5	15.3	60.5
Denver	59.0	41.0	14.8	62.3
Detroit	58.6	41.4	3.6	84.3
Los Angeles	62.5	37.5	7.9	76.4
Maine	53.9	46.1	20.0	44.3
Maryland	56.2	43.8	8.9	72.8
Broward County	66.1	33.9	11.4	69.8
Miami/Dade County	58.6	41.4	15.0	60.9
Minneapolis/ St. Paul	62.2	37.8	9.4	72.4
New York City	68.7	31.3	5.4	79.3
Philadelphia	70.8	29.2	11.2	64.1 <sup>5</sup>
Phoenix	53.0	47.0	10.2 <sup>6</sup>	75.0
St. Louis	65.7	34.3	6.0	79.7
San Diego	64.4	35.6	11.5	73.0
Seattle	62.6	37.4	7.3	60.8 <sup>7</sup>
Texas	50.7	49.3	14.9	57.3

<sup>1</sup>Percentages are rounded to one decimal place.<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for calendar year 2009: January–December 2009.<sup>4</sup>Percentages may not sum to 100 due to the presence of unknown gender.<sup>5</sup>Data from Philadelphia are for age 36 and older.<sup>6</sup>Treatment data for Phoenix do not include admissions younger than age 18.<sup>7</sup>Data from Seattle are for age 40 and older.

SOURCE: June 2010 State and local CEWG reports

more recent period, 2008 to 2009. Declines ranged from a low (0.8–1.6 percentage points) in Baltimore, San Diego, and Hawaii, to a high of an approximately 8-percentage-point decline in Seattle and Minneapolis/St. Paul. Nine areas (Atlanta, Denver, Detroit, Los Angeles, Maine, New York City, Phoenix, St. Louis, and Texas) reported moderate declines of between approximately 2 and 6 percentage points over the 2 years (table 7).

### Forensic Laboratory Data on Cocaine/Crack

According to NFLIS data in 2009, cocaine was the drug most frequently reported for 7 of the 22 CEWG areas shown on the map (figure 22) and table (table 2) in section II. Cocaine items as a

percentage of the total drug items reported in the NFLIS system were particularly high in the Miami/Dade MSA (61.8 percent) and Atlanta (48.7 percent). The lowest reported frequencies of cocaine drug items among those identified in forensic laboratories were in St. Louis and San Diego, at 14.8 percent and 9.4 percent, respectively (figure 23; appendix table 2).

Based on rankings shown in section II, table 2, in three of the five southern region CEWG areas (Miami, Atlanta, and Washington, DC), cocaine ranked as the most frequently identified drug in forensic laboratories in 2009. In three of the four CEWG areas in the northeastern region, Boston, Maine, and New York City, cocaine ranked first among drug items identified. It was first in one

**Table 7. Primary Cocaine Treatment Admissions in 14 CEWG Areas as a Percentage of Total Drug Treatment Admissions, Excluding Primary Alcohol Admissions, and Percentage-Point Changes for Two Time Periods: 2005–2009 and 2008–2009**

CEWG Area/State	Year (in Percent)					Percentage-Point Change	
	2005 <sup>1</sup>	2006 <sup>2</sup>	2007 <sup>3</sup>	2008 <sup>3</sup>	2009 <sup>3</sup>	2005–2009	2008–2009
Atlanta	49.8	50.6	38.4	34.7	30.3	-19.5	-4.4
Baltimore	16.4	17.7	18.7	17.4	16.6	0.2	-0.8
Denver	20.0	23.5	23.4	22.1	18.1	-1.9	-4.0
Detroit	34.7	41.1	37.7	31.0	27.2	-7.5	-3.8
Hawaii	4.1	6.3	5.7	6.2	4.6	0.5	-1.6
Los Angeles	20.5	20.9	19.9	19.8	16.4	-4.1	-3.4
Maine	12.7	14.2	13.7	10.5	7.2	-5.5	-3.3
Minneapolis/St. Paul	26.5	27.3	23.7	20.9	13.2	-13.3	-7.7
New York City	29.2	29.9	28.1	25.7	22.9	-6.3	-2.8
Phoenix	16.1	15.2	14.5	12.8	8.1	-8.0	-4.7
St. Louis	33.5	33.8	35.5	26.8	21.1	-12.4	-5.7
San Diego	8.2	8.2	8.5	8.3	6.8	-1.4	-1.5
Seattle	24.6	25.6	27.2	27.0	19.1	-5.5	-7.9
Texas	34.1	32.4	31.5	29.6	24.7	-9.4	-4.9

<sup>1</sup>Detroit reported FY 2005 (July 2004–June 2005) data; all others reported full year CY 2005 data.

<sup>2</sup>Detroit reported FY 2006 (July 2005–June 2006) data; Atlanta, Los Angeles, and San Diego reported first half CY 2006 (January–June 2006) data; all others reported full year CY 2006 data.

<sup>3</sup>Calendar year (January–December) data.

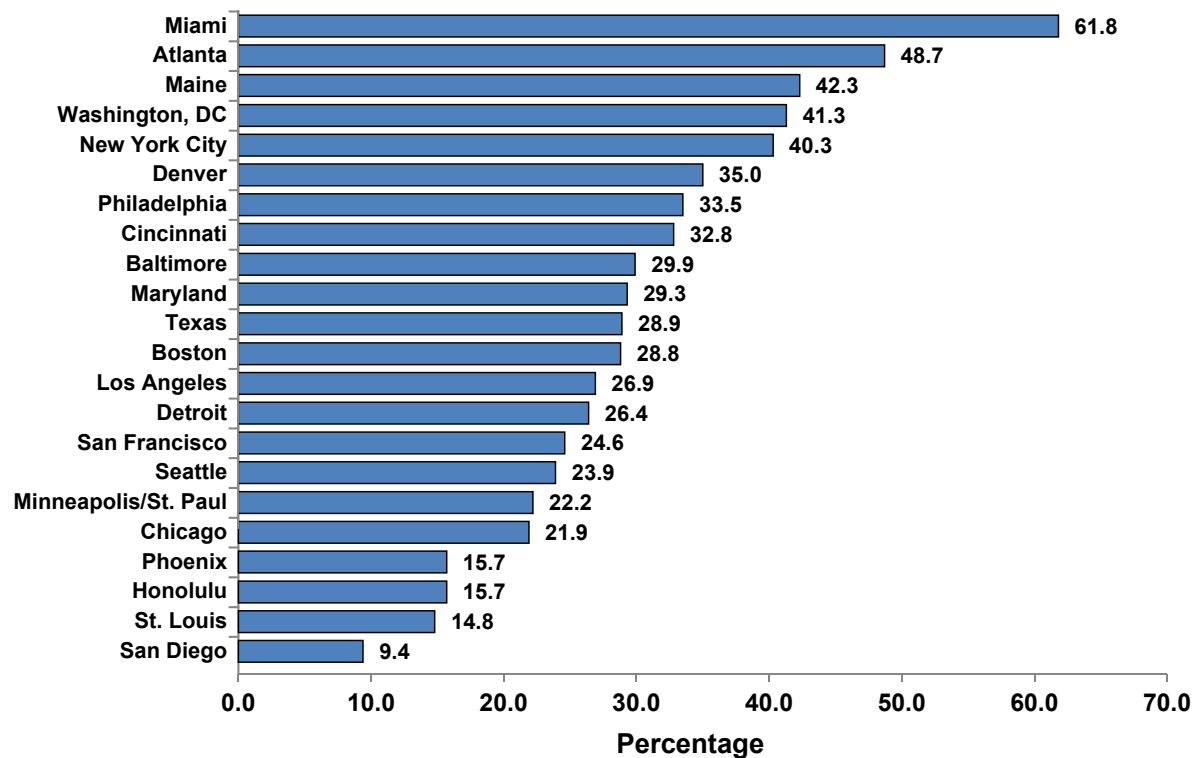
SOURCES: June 2010 State and local CEWG reports; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 40; *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 70; *June 2007 Highlights and Executive Summary Volume I* CEWG report, p. 15; and *June 2006 Highlights and Executive Summary Volume I* CEWG report, pp. 29 and 71



of eight areas in the western region (Denver). Cocaine ranked first in none of the five areas in the midwestern region. Cocaine ranked second in drug items identified in 2009 in 11 of 22 CEWG

reporting areas: Baltimore, Maryland, Philadelphia, Chicago, Cincinnati, Detroit, St. Louis, Los Angeles, San Francisco, Seattle, and Texas.

**Figure 23. Cocaine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: CY 2009<sup>1</sup>**



<sup>1</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

SOURCE: NFLIS, DEA, data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010; see appendix tables 2.1–2.22

## Heroin

- Heroin primary treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore (approximately 53 percent) and Boston (51 percent) in 2009 (table 8). In Boston, Baltimore, and Detroit, heroin was the substance most frequently reported as the primary problem at treatment admission in the reporting period. It ranked second in three areas, namely Maryland, New York City, and St. Louis (section II, table 3; appendix table 1).
- Injection of heroin was the main mode of administration of the drug reported among primary heroin treatment admissions in 2009 in most areas, with the exception of Baltimore, Detroit, and New York City, where inhalation was more commonly reported as the major route of administration (table 9).
- The largest increases in the proportion of primary heroin treatment admissions, excluding primary alcohol admissions, from 2008 to 2009 among the 11 of 14 reporting CEWG areas experiencing increases were seen in St. Louis, Phoenix, and Denver, where proportions of heroin admissions increased by 6.7, 4.6, and 3.1 percentage points, respectively. In three areas, Baltimore, Hawaii, and New York City, proportions of primary heroin admissions declined by approximately 1 percentage point or less in the 2-year period. In the 5 years between 2005 and 2009, 5 of 14 reporting areas saw declines in proportions of primary heroin treatment admissions, while 8 areas showed increases, and in 1 area (Los Angeles), no change was observed over the period. St. Louis and Phoenix had the largest increases in primary heroin treatment admissions, at 19.1 and 10.7 percentage points, respectively, with the largest declines of approximately 4–5 percentage points noted for Seattle, Maine, and New York City (table 11).
- In one-half (11) of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in 2009, compared with 17 of 22 areas in 2008. Proportions were highest in Baltimore and Maryland (approximately 22 and 20 percent, respectively). They were lowest in Honolulu and Atlanta, at approximately 1–2 percent of drug items identified in each area (figure 24; appendix table 2). Heroin was not ranked first in drug items seized in any CEWG area, although it ranked second in Maine in 2009 (section II, table 2).

### Treatment Admissions Data on Heroin

In this 2009 reporting period for 18 of 22 CEWG areas, primary heroin treatment admissions, as a proportion of total admissions for substance abuse treatment, including primary alcohol admissions, ranged from approximately 2 percent to approximately 53 percent. After Baltimore at 52.5 percent, Boston had the highest proportion of heroin admissions, at 51.0 percent of all admissions (table 8; see also appendix table 1). The lowest percentages of primary heroin admissions were in Broward County and Hawaii, at 1.8 and 1.9 percent, respectively.

When all admissions, including those for whom alcohol was the primary drug, are examined, heroin ranked first in 3 of the 22 CEWG reporting areas: Baltimore, Boston, and Detroit. Heroin ranked second in three areas (Maryland, New York City, and St. Louis) among all treatment admissions. Heroin ranked third in five areas; these areas were Cincinnati, San Francisco, Los Angeles, Phoenix, and Seattle (section II, table 3).

### Route of Administration of Heroin.

Injection was the most frequently reported mode of heroin administration in 14 of 18 reporting CEWG areas in 2009. Proportions of heroin admissions injecting the drug ranged from a low of

**Table 8. Primary Heroin Treatment Admissions in 22 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions<sup>1</sup>: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas	Primary Heroin Admissions	Total Admissions with Primary Alcohol Admissions Excluded <sup>4</sup>		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2009					
Cincinnati <sup>5</sup>	775	3,704	20.9	5,480	14.1
San Francisco	5,686	22,652	25.1	32,141	17.7
CY 2009					
Atlanta	363	4,830	7.5	9,333	3.9
Baltimore	9,137	14,478	63.1	17,397	52.5
Boston	10,025	13,392	74.9	19,638	51.0
Colorado	1,570	16,470	9.5	28,510	5.5
Denver	960	7,350	13.1	11,947	8.0
Detroit	3,211	6,643	48.3	9,368	34.3
Hawaii	170	7,229	2.4	8,930	1.9
Los Angeles	9,978	40,916	24.4	53,036	18.8
Maine	1,250	8,017	15.6	14,498	8.6
Maryland	16,170	40,638	39.8	60,404	26.8
Broward County	105	4,424	2.4	5,678	1.8
Miami/Dade County	150	4,253	3.5	5,542	2.7
Minneapolis/St. Paul	1,644	9,961	16.5	20,645	8.0
New York City	21,931	59,980	36.6	83,401	26.3
Philadelphia	1,994	11,375	17.5	14,864	13.4
Phoenix <sup>6</sup>	751	2,906	25.8	4,481	16.8
St. Louis	2,630	7,499	35.1	11,677	22.5
San Diego	2,763	11,284	24.5	14,258	19.4
Seattle	1,538	7,560	20.3	12,986	11.8
Texas	11,368	65,784	17.3	91,072	12.5

<sup>1</sup>More information on these data is available in the footnotes and notes for appendix table 1.<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for calendar year 2009: January–December 2009.<sup>4</sup>For comparability with past data, percentages of primary heroin admissions are obtained from admissions with primary alcohol admissions excluded.<sup>5</sup>Heroin and other opiates are grouped together for Cincinnati and are reported in this Heroin table only.<sup>6</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports

approximately 40 percent (New York City and Detroit) to a high of 87.6 percent in Broward County, followed by Boston at 84.2 percent. The percentage of injection among heroin treatment admissions was approximately 80 percent in Los Angeles, and it was 70–79 percent in Denver, Colorado, Phoenix, Maine, San Diego, and Texas in 2009. Areas with approximately 40–43 percent of heroin admissions who were injectors were New York City, Detroit, Philadelphia<sup>20</sup>, and Baltimore. Inhalation or intranasal use was the most frequent mode of heroin administration reported by heroin admissions in 3 of 18 areas: Detroit, at 58.9 percent, New York City, at 58.0 percent, and Baltimore, at 55.6 percent. However, this mode was relatively rarely reported among treatment admissions in San Diego, Los Angeles, Denver, and Colorado (3.5, 3.9, 5.2, and 5.7 percent, respectively). Smoking was reported by less than 2 percent of the heroin admissions in 11 of 18 CEWG areas reporting. San Diego had the highest proportion of heroin treatment admissions whose primary mode of administration was smoking, at 21.0 percent, followed by Phoenix, Denver, Colorado, and Los Angeles, at between approximately 13 and 17 percent (table 9).

**Gender of Heroin Admissions.** There were proportionally more male than female primary heroin admissions in all except 1 of the 20 CEWG areas in 2009 represented in table 10. The largest proportions of male heroin admissions were in Broward County, at 79.0 percent, and New York City (77.6 percent). Conversely, the largest proportions of females were in Cincinnati and Maine, at approximately 54 and 44 percent, respectively.

**Age of Heroin Admissions.** In 7 of 20 reporting CEWG areas, more than one-half of the primary heroin admissions in 2009 were age 35 or older, with the highest proportions in Detroit (88.4 percent) and Baltimore (82.6 percent).

Maine reported the highest percentages of heroin treatment admissions among those age 25 and younger, at 38.2 percent, followed by Phoenix, at 31.8 percent (table 10).

### Changes in Heroin Admissions, 2005–2009

Over the period from 2005 through 2009, proportions of primary heroin treatment admissions, excluding primary alcohol admissions, increased in 8 of 14 reporting areas, namely Atlanta, Baltimore, Detroit, Minneapolis/St. Paul, San Diego, Texas, Phoenix, and St. Louis. These last two areas showed the largest increases of 10.7 and 19.1 percentage points, respectively. Declines in heroin admissions were found for 5 of 14 reporting areas, with 1 area showing no change. The highest decreases over the 5-year period were for Seattle, Maine, and New York City (at 5.1, 4.9, and 4.2 percentage points, respectively). The respective declines in heroin admissions were small in Denver and Hawaii (at 1.0 and 0.7 percentage points). No change was observed for Los Angeles over the 5-year period (table 11).

During the more recent 2-year period, from 2008 through 2009, 11 of the 14 reporting areas had increases in proportions of primary heroin treatment admissions. Three of the 14 reporting areas showed increases of 3 or more percentage points (St. Louis, Phoenix, and Denver, at 6.7, 4.6, and 3.1 percentage points, respectively), while the other areas had increases of 2 percentage points or less. Decreased proportions of heroin admissions from 2007 to 2009 were noted in three reporting areas, namely Baltimore (1.3 percentage points), Hawaii (0.6 percentage points), and New York City (0.5 percentage points) (table 11).

<sup>20</sup>In Philadelphia, where a relatively large percentage of heroin treatment admissions ( $n=1,994$ ) had unknown route of administration for heroin ( $n=956$ ), 41 percent of admissions in 2009 reported injection as the primary route of heroin administration, while 77 percent of those with a known route of heroin administration were injectors.

**Table 9. Primary Route of Administration of Heroin Among Treatment Admissions in 18 CEWG Areas as a Percentage<sup>1</sup> of Primary Heroin Treatment Admissions: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas <sup>4</sup>	Smoked		Inhaled		Injected		Other/ Unknown		Total N
	#	%	#	%	#	%	#	%	
CY 2009									
Atlanta	5	1.4	91	25.1	249	68.6	18	5.0	363
Baltimore	64	0.7	5,084	55.6	3,940	43.1	49	0.5	9,137
Boston	66	0.7	1,401	14.0	8,446	84.2	112	1.1	10,025
Colorado	211	13.4	89	5.7	1,241	79.0	29	1.8	1,570
Denver	143	14.9	50	5.2	749	78.0	18	1.9	960
Detroit	13	0.4	1,890	58.9	1,350	40.6	3	0.1	3,211
Los Angeles	1,370	13.7	392	3.9	8,031	80.5	185	1.9	9,978
Maine	13	1.0	245	19.6	935	74.8	57	4.6	1,250
Maryland	115	0.7	6,567	40.6	9,323	57.7	165	1.0	16,170
Broward County	2	1.9	8	7.6	92	87.6	3	2.9	105
Miami/Dade County	13	8.7	41	27.3	92	61.3	4	2.7	150
Minneapolis/St. Paul	77	4.7	505	30.7	1,030	62.7	32	1.9	1,644
New York City	148	0.7	12,722	58.0	8,849	40.3	212	1.0	21,931
Philadelphia	8	0.4	201	10.1	829	41.6	956	47.9	1,994
Phoenix <sup>5</sup>	131	17.4	51	6.8	537	71.5	32	4.3	751
St. Louis	25	1.0	1,069	40.6	1,502	57.1	34	1.3	2,630
San Diego	579	21.0	98	3.5	2,072	75.0	14	0.5	2,763
Texas	108	1.0	2,216	19.5	8,736	76.8	308	2.7	11,368

<sup>1</sup>Percentages may not sum to 100 due to rounding.<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for calendar year 2009: January–December 2009.<sup>4</sup>No data were available for Cincinnati, Hawaii, San Francisco, and Seattle.<sup>5</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports



**Table 10. Demographic Characteristics of Primary Heroin Treatment Admissions in 20 CEWG Areas as a Percentage<sup>1</sup>: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas	Gender <sup>4</sup>		Age Group	
	Percent Male	Percent Female	Percent 25 and Younger	Percent 35 or Older
FY 2009				
Cincinnati <sup>5</sup>	46.2	53.8	27.2	34.8
CY 2009				
Atlanta	65.0	35.0	25.3	51.5
Baltimore	61.5	38.5	5.1	82.6
Boston	71.4	28.4	24.2	42.6
Colorado	66.4	33.6	25.3	43.3
Denver	63.8	36.3	24.5	45.6
Detroit	61.4	38.6	3.4	88.4
Los Angeles	71.7	28.2	16.2	64.9
Maine	56.2	43.8	38.2	20.0
Maryland	61.4	38.6	19.5	60.0
Broward County	79.0	21.0	20.0	38.1
Miami/Dade County	72.7	27.3	16.7	58.7
Minneapolis/ St. Paul	66.4	33.6	26.4	48.5
New York City	77.6	22.4	5.7	76.4
Philadelphia	72.1	27.9	20.9	41.5 <sup>6</sup>
Phoenix	63.8	36.2	31.8 <sup>7</sup>	43.9
St. Louis	59.2	40.8	28.3	30.6
San Diego	70.8	29.2	26.3	44.3
Seattle	60.6	39.4	19.8	45.1 <sup>8</sup>
Texas	62.4	37.6	28.9	38.5

<sup>1</sup>Percentages are rounded to one decimal place.<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for calendar year 2009: January–December 2009.<sup>4</sup>Percentages may not sum to 100 percent due to the presence of unknown gender.<sup>5</sup>Heroin and other opiates are grouped together for Cincinnati and are reported in this Heroin table only.<sup>6</sup>Data from Philadelphia are for age 36 and older.<sup>7</sup>Treatment data for Phoenix do not include admissions younger than age 18.<sup>8</sup>Data from Seattle are for age 40 and older.

SOURCE: June 2010 State and local CEWG reports

**Table 11. Primary Heroin Treatment Admissions in 14 CEWG Areas as a Percentage of Total Admissions, Excluding Primary Alcohol Admissions, and Percentage-Point Changes for Two Time Periods: 2005–2009 and 2008–2009**

CEWG Area/State	Year (in Percent)					Percentage-Point Change	
	2005 <sup>1</sup>	2006 <sup>2</sup>	2007 <sup>3</sup>	2008 <sup>3</sup>	2009 <sup>3</sup>	2005–2009	2008–2009
Atlanta	7.0	7.2	5.7	6.5	7.5	+0.5	+1.0
Baltimore	59.5	54.3	63.8	64.4	63.1	+3.6	-1.3
Denver	14.1	10.6	10.5	10.0	13.1	-1.0	+3.1
Detroit	43.6	38.1	39.4	47.2	48.3	+4.7	+1.1
Hawaii	3.1	3.3	2.9	3.0	2.4	-0.7	-0.6
Los Angeles	24.4	24.3	24.1	23.5	24.4	0.0	+0.9
Maine <sup>4</sup>	20.5	18.7	15.0	14.9	15.6	-4.9	+0.7
Minneapolis/ St. Paul	9.8	11.2	13.0	14.1	16.5	+6.7	+2.4
New York City	40.8	37.9	38.2	37.1	36.6	-4.2	-0.5
Phoenix	15.1	16.7	14.8	21.2	25.8	+10.7	+4.6
St. Louis	16.0	17.5	24.1	28.4	35.1	+19.1	+6.7
San Diego	22.8	22.3	21.5	23.1	24.5	+1.7	+1.4
Seattle	25.4	20.9	18.7	19.6	20.3	-5.1	+0.7
Texas	11.6	12.8	13.0	15.3	17.3	+5.7	+2.0

<sup>1</sup>Detroit reported FY 2005 (July 2004–June 2005) data; all others reported full year CY 2005 data.

<sup>2</sup>Detroit reported FY 2006 (July 2005–June 2006) data; Atlanta, Los Angeles, and San Diego reported first half CY 2006 (January–June 2006) data; all others reported full year CY 2006 data.

<sup>3</sup>Calendar year (January–December) data.

<sup>4</sup>Includes morphine as well as heroin.

SOURCES: June 2010 State and local CEWG reports; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 47; *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 71; *June 2007 Highlights and Executive Summary Volume I* CEWG report, p. 25; and *June 2006 Highlights and Executive Summary Volume I* CEWG report, p. 17

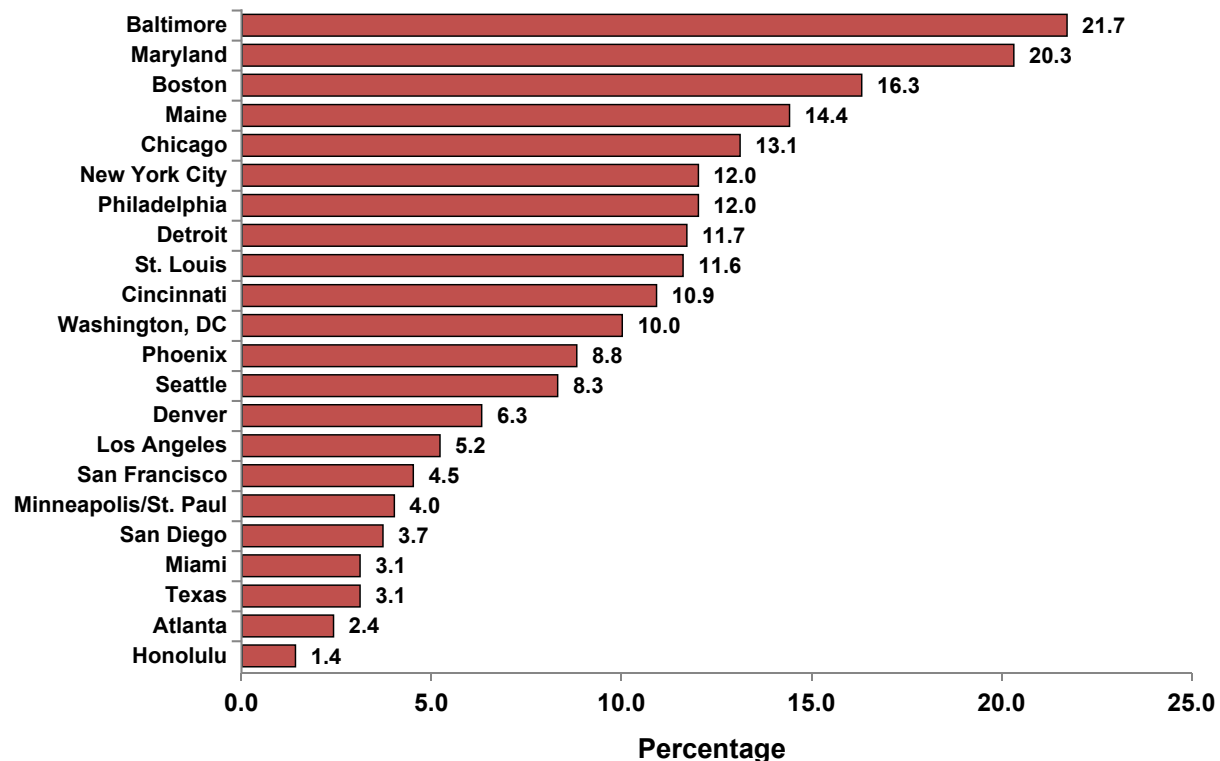
## Forensic Laboratory Data on Heroin

In one-half (11) of the 22 CEWG areas shown on the map in figure 22 (section II), heroin items accounted for less than 10 percent of the total drug items reported by NFLIS. As a proportion of total drug items, heroin items were highest in Baltimore (21.7 percent) and Maryland (20.3 percent), compared with other CEWG areas. Heroin drug items identified were lowest in Honolulu (1.4 percent) and Atlanta (2.4 percent) (figure 24; appendix table 2).

Heroin was not ranked as the number one most frequently identified drug in any of the CEWG

areas in 2009 (section II, table 2), and it appeared as second in Maine but placed no higher than third in the rankings of drug items identified in that reporting period in the other 21 reporting areas. However, it ranked third in all areas within the northeastern, southern, and midwestern regions, with the exception of Maine (where it ranked second as noted), Atlanta (where it ranked sixth), and Minneapolis/St. Paul (where it ranked fifth) in the Northeast, South, and Midwest, respectively. In the West, heroin ranked no higher than fourth in any area.

**Figure 24. Heroin Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: CY 2009<sup>1</sup>**



<sup>1</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

SOURCE: NFLIS, DEA, data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010; see appendix tables 2.1–2.22

## Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

- Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from 2.0 percent (Miami/Dade County) to 9.1 percent (Maryland) in 18 of 19 reporting CEWG areas in 2009. The outlier was Maine, where nearly 29 percent of primary treatment admissions were for other opiate problems (table 12; appendix table 1).
- While none of the 19 CEWG areas reporting on opiates other than heroin ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, other opiates ranked second in Maine and third in Minneapolis/St. Paul (section II, table 3).
- From 2008 to 2009, of 13 reporting CEWG areas, 11 reported increases in other opiate treatment admission proportions, excluding primary alcohol admissions, with the largest increase being in Minneapolis/St. Paul (4.3 percentage points). One area (San Diego) saw no change, while a decline of 1.8 percentage points was noted for Maine. In the 5-year period from 2005 to 2009, all but one area (Baltimore) showed increased proportions of other opiate treatment admissions; Maine had the largest such increase, at 14.4 percentage points (table 14).
- Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in 2009. In Atlanta, Baltimore, Maryland, Boston, Maine, Philadelphia, and Cincinnati, oxycodone ranked fourth in drug items identified, and it ranked fifth in New York City, Phoenix, and Seattle. Hydrocodone ranked fourth in Detroit and fifth in frequency of drug items identified in Atlanta, Cincinnati, San Diego, and Texas. Buprenorphine ranked fifth in identified NFLIS drug items in Baltimore and Maryland in 2009, sixth in Boston, seventh in Washington, DC (where it was tied with TFMPP) and Maine, and eighth in Seattle. Methadone ranked in the top 10 identified drugs in New York City (seventh), Baltimore and San Francisco (eighth each), and Maryland and Maine (ninth each) during this reporting period (section II, table 2).

### Treatment Admissions Data on Opiates/Opioids Other Than Heroin

In 2009, 19 CEWG areas provided data on treatment admissions for primary abuse of opiates other than heroin as a category separate from heroin (table 12; appendix table 1). Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 2 to 9 percent in 18 of the 19 reporting CEWG areas. Including primary alcohol admissions, the other opiates admissions group accounted for a high of 28.9 percent of the primary treatment admissions in Maine. This was followed distantly by

Maryland and Minneapolis/St. Paul, where 9.1 and 8.3 percent, respectively, of total primary treatment admissions were for other opiates. At the low end of the range, other opiates accounted for approximately 2–4 percent of total admissions in Baltimore, Boston, Detroit, Los Angeles, Miami/Dade County, New York City, Philadelphia, Phoenix, St. Louis, and San Diego (table 12). While none of the 19 CEWG areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, in Maine other opiates ranked second, while the category ranked third in Minneapolis/St. Paul (section II, table 3).

**Table 12. Primary Other Opiate Treatment Admissions in 19 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions<sup>1</sup>: CY 2009<sup>2</sup>**

CEWG Areas <sup>3</sup>	Primary Other Opiates Admissions	Total Admissions with Primary Alcohol Admissions Excluded <sup>4</sup>		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	484	4,830	10.0	9,333	5.2
Baltimore	569	14,478	3.9	17,397	3.3
Boston	859	13,392	6.4	19,638	4.4
Colorado	1,475	16,470	9.0	28,510	5.2
Denver	627	7,350	8.5	11,947	5.2
Detroit	203	6,643	3.1	9,368	2.2
Los Angeles	1,315	40,916	3.2	53,036	2.5
Maine	4,185	8,017	52.2	14,498	28.9
Maryland	5,476	40,638	13.5	60,404	9.1
Broward County	336	4,424	7.6	5,678	5.9
Miami/Dade County	113	4,253	2.7	5,542	2.0
Minneapolis/St. Paul	1,722	9,961	17.3	20,645	8.3
New York City	1,286	59,980	2.1	83,401	1.5
Philadelphia	513	11,375	4.5	14,864	3.5
Phoenix <sup>5</sup>	184	2,906	6.3	4,481	4.1
St. Louis	313	7,499	4.2	11,677	2.7
San Diego	553	11,284	4.9	14,258	3.9
Seattle	722	7,560	9.6	12,986	5.6
Texas	5,844	65,784	8.9	91,072	6.4

<sup>1</sup>More information on these data is available in the footnotes and notes for appendix table 1.

<sup>2</sup>Data are for January–December 2009.

<sup>3</sup>Heroin and Other Opiates are grouped together for Cincinnati and are reported in the Heroin table only. Data for this table were not reported for San Francisco and Hawaii. For further information see appendix table 1.

<sup>4</sup>Percentages of primary other opiates admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

<sup>5</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports



**Gender of Other Opiate Admissions.**

A majority of primary admissions for other opiates were male in 14 of 19 reporting CEWG areas, with the highest male percentages in Philadelphia (75.8 percent) and New York City (68.7 percent). However, females predominated in Baltimore, Detroit, Phoenix, St. Louis, and Texas among treatment admissions for other opiates (table 13).

**Age of Other Opiate Admissions.**

In only 2 of 19 CEWG areas reporting, namely Detroit and Los Angeles, a majority of primary other opiate admissions were age 35 or older (approximately 71 and 58 percent, respectively). The age group 25 and younger was more highly represented among other opiate admissions in Seattle (44.2 percent), Philadelphia (41.5 percent), and Maryland (41.3 percent) than other CEWG areas (table 13).

**Table 13. Demographic Characteristics of Primary Treatment Admissions for Opiates/Opioids Other Than Heroin in 19 CEWG Areas, by Percent<sup>1</sup>: CY 2009<sup>2</sup>**

CEWG Areas <sup>3</sup>	Gender <sup>4</sup>		Age Group	
	Percent Male	Percent Female	Percent 25 and Younger	Percent 35 or Older
Atlanta	55.4	44.6	34.9	36.4
Baltimore	40.6	59.4	23.2	48.5
Boston	60.8	39.1	27.0	42.7
Colorado	52.9	47.1	26.2	40.6
Denver	52.8	47.2	27.6	38.0
Detroit	37.9	62.1	10.8	70.9
Los Angeles	58.2	41.7	19.3	57.6
Maine	51.1	48.9	37.8	23.2
Maryland	53.7	46.3	41.3	29.2
Broward County	54.8	45.2	37.2	30.7
Miami/Dade County	58.4	41.6	22.1	37.2
Minneapolis/St. Paul	54.1	45.9	28.7	41.2
New York City	68.7	31.3	28.8	44.2
Philadelphia	75.8	24.2	41.5	21.6 <sup>5</sup>
Phoenix	47.3	52.7	31.0 <sup>6</sup>	33.7
St. Louis	49.8	50.2	27.2	32.3
San Diego	61.1	38.9	30.4	40.5
Seattle	53.3	46.7	44.2	16.8 <sup>7</sup>
Texas	42.5	57.5	21.1	37.7

<sup>1</sup>Percentages are rounded to one decimal place.

<sup>2</sup>All areas reported calendar year 2009 data: January–December 2009.

<sup>3</sup>Heroin and Other Opiates are grouped together for Cincinnati and are reported in the Heroin table only. Data for this table were not reported for San Francisco and Hawaii. For further information see appendix table 1.

<sup>4</sup>Percentages may not sum to 100 percent due to the presence of unknown gender.

<sup>5</sup>Data from Philadelphia are for age 36 and older.

<sup>6</sup>Treatment data for Phoenix do not include admissions younger than age 18.

<sup>7</sup>Data from Seattle are for age 40 and older.

SOURCE: June 2010 State and local CEWG reports

## Changes in Other Opiate Admissions, 2005–2009

Of the 11 CEWG areas reporting data on other opiate treatment admissions, excluding primary alcohol admissions, all but 1 area, Baltimore, showed increased percentages of such admissions in 2009 compared with 2005 (table 14). Increases ranged from approximately 1 percentage point in Detroit and New York City to 14.4 percentage points in Maine over the 5 years. In Baltimore,

a 3-percentage-point decrease in other opiate admissions was noted over the 2005–2009 period (table 14).

In the 2 years from 2008 to 2009, 11 of 13 reporting CEWG areas showed increases in other opiate admissions. The largest increase was for Minneapolis/St. Paul, at 4.3 percentage points. No change in proportions of other opiate admissions was observed for San Diego, while Maine saw a decline of 1.8 percentage points in such admissions from 2008 to 2009 (table 14).

**Table 14. Treatment Admissions with a Primary Substance Abuse Problem With Opiates Other Than Heroin in 13 CEWG Areas as a Percentage of Total Drug Treatment Admissions, Excluding Primary Alcohol Admissions, and Percentage-Point Changes for Two Time Periods: 2005–2009 and 2008–2009**

CEWG Area/State	Year (in Percent)					Percentage-Point Change	
	2005 <sup>1</sup>	2006 <sup>2</sup>	2007 <sup>3</sup>	2008 <sup>3</sup>	2009 <sup>3</sup>	2005–2009	2008–2009
Atlanta	NR <sup>4</sup>	NR	6.1	7.8	10.0	--	+2.2
Baltimore	6.9	7.7	3.6	3.6	3.9	-3.0	+0.3
Denver	6.1	5.3	5.2	6.2	8.5	+2.4	+2.3
Detroit	2.1	1.6	1.8	2.1	3.1	+1.0	+1.0
Los Angeles	1.2	1.9	2.8	1.9	3.2	+2.0	+1.3
Maine	37.8	42.3	47.6	54.0	52.2	+14.4	-1.8
Minneapolis/ St. Paul	NR	7.3	10.1	13.0	17.3	--	+4.3
New York City	1.0	1.0	1.2	1.7	2.1	+1.1	+0.4
Phoenix	NR	5.0	4.7	5.0	6.3	--	+1.3
St. Louis	1.6	0.7	2.9	3.0	4.2	+2.6	+1.2
San Diego	2.2	4.1 <sup>5</sup>	4.9	4.9	4.9	+2.7	0.0
Seattle	5.2	6.1	6.5	6.8	9.6	+4.4	+2.8
Texas	6.4	6.3	7.0	8.3	8.9	+2.5	+0.6

<sup>1</sup>Detroit reported FY 2005 (July 2004–June 2005); all others reported full year CY 2005 data.

<sup>2</sup>Detroit reported FY 2006 (July 2005–June 2006) data; Los Angeles reported first half CY 2006 (January–June 2006) data; all others reported full year CY 2006 data.

<sup>3</sup>Calendar year (January–December) data.

<sup>4</sup>NR=Not reported by the CEWG area representative.

<sup>5</sup>The San Diego representative provided updated data for CY 2006, replacing the previous value of 2.9 percent for the first half of CY 2006.

SOURCES: June 2010 State and local CEWG reports; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 54; *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 42; *June 2007 Highlights and Executive Summary Volume I* CEWG report, p.36; *June 2006 Highlights and Executive Summary Volume I* CEWG report, pp. 24 and 71; and an update for San Diego in June 2010

### Forensic Laboratory Data on Opiates/ Opioids Other Than Heroin (Narcotic Analgesics)

Of the narcotic analgesic/opiate items identified by forensic laboratories across CEWG areas in 2009, oxycodone and hydrocodone were the two most frequently reported in most areas. However, they rarely accounted for more than 7 percent of all drug items identified in any area (table 15; appendix table 2).

**Oxycodone.** Maine reported the highest frequency of oxycodone items identified in forensic laboratories in the period (at 7.3 percent), followed by Seattle (6.9 percent) and Boston (6.6 percent) (table 15). Oxycodone ranked fourth in drug items identified in Atlanta, Baltimore, Maryland, Boston, Maine, Philadelphia, and Cincinnati. It ranked fifth in frequency of drug items identified in forensic laboratories in three other CEWG areas—New York City, Phoenix, and Seattle. Oxycodone ranked sixth in Minneapolis/St. Paul and Denver (section II, table 2). In 6 of 22 CEWG areas, oxycodone represented less than 1 percent of the total drug items identified in the reporting period (table 15).

**Hydrocodone.** Hydrocodone ranked fourth in drug items identified in Detroit and fifth in drug items identified in 4 of 22 areas, namely Atlanta, Cincinnati, San Diego, and Texas (section II, table 2). Identified percentages ranged from 4.5 percent in Atlanta and 3.9 percent in Texas to less than 1.0 percent in 9 of 22 areas reporting in 2009 (table 15).

**Buprenorphine.** Baltimore, Boston, Maine, Maryland, and Seattle were the only CEWG areas with at least 1 percent of drug items identified containing buprenorphine. Percentages were 1.5, 2.4, 2.4, 1.4, and 1.5, respectively (table 15). According to NFLIS data in section II, table 2, buprenorphine ranked fifth in identified drugs in Baltimore and Maryland, sixth in Boston, seventh in Washington, DC, and Maine, and eighth in Seattle in 2009.

**Methadone.** Maine, New York City, and San Francisco were the only areas reporting a percentage of 1 or higher for methadone drug items, at 1.8, 1.2, and 1.2 percent, respectively (table 15). Methadone ranked seventh in identified drugs in New York City, eighth in Baltimore and San Francisco, and ninth in Maryland and Maine during this reporting period (section II, table 2).

**Table 15. Selected Narcotic Analgesic Items Identified by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified<sup>1</sup>: 2009<sup>2</sup>**

CEWG Area	Oxycodone		Hydrocodone		Methadone		Fentanyl		Buprenorphine		Total Items
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	
Atlanta	524	4.5	515	4.5	95	*	--	*	26	*	11,557
Baltimore	948	1.9	137	*	181	*	--	*	787	1.5	50,870
Boston	1,149	6.6	171	1.0	96	*	--	*	419	2.4	17,394
Chicago	102	*	508	*	113	*	--	*	104	*	81,383
Cincinnati	404	3.2	211	1.7	55	*	2	*	24	*	12,497
Denver	152	2.0	113	1.5	18	*	3	*	6	*	7,676
Detroit	65	*	338	3.3	10	*	3	*	21	*	10,121
Honolulu	15	*	2	*	5	*	--	*	--	*	1,594
Los Angeles	180	*	772	1.7	77	*	--	*	42	*	46,300
Maine	61	7.3	19	2.3	15	1.8	1	*	20	2.4	832
Maryland	956	1.7	140	*	181	*	--	*	788	1.4	55,149
Miami	339	1.4	65	*	14	*	--	*	15	*	24,772
Minneapolis/ St. Paul	116	2.6	37	*	14	*	--	*	15	*	4,483
New York City	1,050	2.0	412	*	645	1.2	10	*	340	*	52,677
Philadelphia	1,391	4.0	223	*	102	*	17	*	121	*	34,929
Phoenix	229	3.6	144	2.3	20	*	--	*	23	*	6,369
St. Louis	266	1.5	374	2.1	43	*	6	*	73	*	17,851
San Diego	321	1.5	447	2.1	92	*	--	*	70	*	20,941
San Francisco	426	2.7	441	2.8	194	1.2	5	*	18	*	15,659
Seattle	180	6.9	32	1.2	23	*	--	*	39	1.5	2,618
Texas	438	*	4,017	3.9	313	*	--	*	88	*	103,085
Washington, DC	28	*	4	*	7	*	--	*	30	*	3,520

<sup>1</sup>Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol \*.

<sup>2</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

SOURCE: NFLIS, DEA, data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010; see appendix 2.1–2.22; data are subject to change and may differ according to the date on which they were queried

## Benzodiazepines/Depressants

- Atlanta and Texas had the highest percentages of alprazolam drug items identified in forensic laboratories in 2009, at 5.0 and 4.6 percent, respectively (table 16). Alprazolam ranked 3rd in frequency among the top 10 drug items identified in forensic laboratories in Atlanta, and ranked 4th in 3 CEWG areas: Miami, New York City, and Texas (section II, table 2).
- Drug items containing clonazepam accounted for 2.7 percent of all drug items in Boston (table 16), where clonazepam figured as the fifth most frequently identified drug in forensic laboratories in 2009. It ranked seventh in Baltimore and Maryland and eighth in Philadelphia among drug items identified in the reporting period (section II, table 2).
- Diazepam ranked 9th in San Diego in 2009, but it did not rank in the top 10 most frequently identified in NFLIS forensic laboratories in any other CEWG area in 2009 (section II, table 2).

### Treatment Admissions Data on Benzodiazepines

In most CEWG area treatment data systems, benzodiazepines are included with other depressants, barbiturates, and sedative/hypnotics; these admissions continued to account for small proportions of total treatment admissions. However, some CEWG areas noted that benzodiazepines or sedative/hypnotics were secondary or tertiary drugs of abuse among some treatment admissions.

### Forensic Laboratory Data on Benzodiazepines

Three benzodiazepine-type items—alprazolam, clonazepam, and diazepam—were the most frequently reported benzodiazepines identified by forensic laboratories in 22 CEWG areas in the 2009 reporting period. Table 16 shows the numbers and percentages of drug items containing alprazolam, clonazepam, and diazepam in each of the reporting CEWG areas.

**Alprazolam.** In the 22 CEWG areas for which NFLIS data were reported for 2009, the highest percentages of alprazolam drug items identified were in Atlanta (5.0 percent) and Texas (4.6 percent), followed by Philadelphia (3.5 percent),

New York City (2.8 percent), and Miami (2.3 percent). Alprazolam drug items were reported at 1.0–2.1 percent in Boston, Cincinnati, Detroit, Phoenix, St. Louis, and Seattle, and at less than 1 percent in the remaining 11 reporting CEWG areas (table 16). In section II, table 2, which shows the rankings of the most frequently reported drugs in NFLIS for 2009 data, alprazolam ranked 3rd in frequency among the top 10 drug items identified in Atlanta and 4th in 3 CEWG areas (Miami, New York City, and Texas).

**Clonazepam.** Drug items containing clonazepam accounted for 2.7 percent of all drug items in Boston and 1.0 percent in Maine. Its presence was minimal in the 20 other CEWG areas (table 16). In Boston, clonazepam figured as the fifth most frequently identified drug in forensic laboratories in 2009. Clonazepam ranked 7th in Baltimore and Maryland, 8th in Philadelphia, and was in 10th place in Cincinnati, Phoenix, San Diego, San Francisco, and Texas (section II, table 2).

**Diazepam.** Drug items containing diazepam accounted for less than 1 percent of all drug items in each of the 22 CEWG areas (table 16). However, diazepam ranked ninth in San Diego among drug items identified in NFLIS forensic laboratories in calendar year 2009 (section II, table 2).



**Table 16. Number of Selected Benzodiazepine Items Identified by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified<sup>1</sup>: 2009<sup>2</sup>**

CEWG Area	Alprazolam		Clonazepam		Diazepam		Total Items
	#	(%)	#	(%)	#	(%)	
Atlanta	583	5.0	69	*	56	*	11,557
Baltimore	444	*	237	*	92	*	50,870
Boston	257	1.5	461	2.7	89	*	17,394
Chicago	321	*	61	*	69	*	81,383
Cincinnati	168	1.3	83	*	69	*	12,497
Denver	61	*	28	*	39	*	7,676
Detroit	134	1.3	16	*	26	*	10,121
Honolulu	8	*	3	*	7	*	1,594
Los Angeles	335	*	132	*	142	*	46,300
Maine	1	*	8	1.0	3	*	832
Maryland	446	*	238	*	99	*	55,149
Miami	568	2.3	29	*	31	*	24,772
Minneapolis/St. Paul	32	*	26	*	21	*	4,483
New York City	1,501	2.8	335	*	130	*	52,677
Philadelphia	1,238	3.5	238	*	112	*	34,929
Phoenix	122	1.9	47	*	40	*	6,369
St. Louis	366	2.1	76	*	94	*	17,851
San Diego	189	*	111	*	121	*	20,941
San Francisco	56	*	137	*	121	*	15,659
Seattle	26	1.0	16	*	8	*	2,618
Texas	4,755	4.6	864	*	566	*	103,085
Washington, DC	10	*	--	*	--	*	3,520

<sup>1</sup>Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol \*.

<sup>2</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

SOURCE: NFLIS, DEA, data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010; see appendix 2.1–2.22; data are subject to change and may differ according to the date on which they were queried

## Methamphetamine

- The proportions of primary treatment admissions, including primary alcohol admissions, for methamphetamine abuse in 17 reporting CEWG areas were especially high in Hawaii and San Diego, at approximately 42 and 29 percent, respectively. They were also relatively high in Phoenix and Los Angeles, with respective percentages of approximately 21 and 18 (table 17; appendix table 1).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego and Hawaii, second in Phoenix, third in Colorado and Denver, and fourth in Los Angeles and San Francisco (section II, table 3).
- In all but 2 of the 14 CEWG areas reporting data, smoking was the most common route of administration of methamphetamine among primary treatment admissions; the 2 were Maine and Maryland (table 18).
- Between 2008 and 2009, seven of nine CEWG areas for which data on primary methamphetamine treatment admissions were available had decreases in these admissions as a percentage of total admissions, excluding primary alcohol admissions. The largest decreases over the period were observed for Phoenix (4.6 percentage points), followed by Seattle (3.0 percentage points). Two areas, Hawaii and Atlanta, showed increases in methamphetamine admissions of 1.8 and 0.2 percentage points, respectively, in that 2-year period (table 20). In the 5 years from 2005 to 2009, all nine reporting areas saw declines in methamphetamine admissions. The highest relative declines were in Phoenix, San Diego, and Minneapolis/St. Paul, with respective percentage point declines of 16.4, 13.2, and 10.8 (table 20).
- In 2009, methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu; second in Atlanta, Minneapolis/St. Paul, Phoenix, and San Diego; and third in five CEWG areas: Denver, Los Angeles, San Francisco, Seattle, and Texas (section II, table 2). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 39 percent), followed by Minneapolis/St. Paul (approximately 24 percent), San Francisco (approximately 22 percent), and Atlanta (approximately 21 percent). In contrast, less than 2 percent of drug items identified as containing methamphetamine were reported in 10 CEWG metropolitan areas east of the Mississippi, including Detroit, Chicago, Miami, New York City, Cincinnati, Boston, Philadelphia, Maryland, Baltimore, and Washington, DC (figure 25; section II, figure 22; appendix table 2).

### Treatment Admissions Data on Methamphetamine

Data on primary methamphetamine treatment admissions in the 2009 reporting period were available and reported for 17 CEWG areas<sup>21</sup>. As a percentage of total treatment admissions, including primary alcohol admissions, Hawaii had the

highest proportion of methamphetamine admissions, at 42.0 percent, followed by San Diego, at 29.2 percent (table 17; appendix table 1). In the same period, primary methamphetamine admissions accounted for approximately 17–21 percent of total primary admissions in San Francisco, Los Angeles, and Phoenix. Five CEWG areas, all east

<sup>21</sup>Data for Baltimore, Cincinnati, Detroit, Broward County, and Philadelphia were excluded due to small numbers (less than 30). These areas reported 9, 11, 3, 20, and 16 total primary methamphetamine-related admissions, respectively.

of the Mississippi River (Boston, Detroit, Maine, Maryland, and New York City), reported that less than 1 percent of admissions were for primary methamphetamine abuse. On the other hand, eight areas—Atlanta, Colorado, Denver, Miami/Dade County, Minneapolis/St. Paul, Seattle, St. Louis, and Texas—reported that between approximately 1 and 15 percent of primary treatment admissions were for methamphetamine abuse problems in this reporting period (table 17). Based on rankings of primary drugs as a percentage of total treatment admissions, including primary alcohol admissions, methamphetamine ranked first in San Diego and Hawaii, second in Phoenix, third in Colorado and Denver, and fourth in Los Angeles and San Francisco (section II, table 3).

**Route of Administration of Methamphetamine.** In the 14 CEWG areas represented in table 18, smoking was the most common mode of administering methamphetamine among primary methamphetamine admissions in all but Maine (21.2 percent) and Maryland (29.8 percent). Smoking was reported at levels ranging from 21.2 percent in Maine to 89.1 percent in Miami/Dade County, with relatively high percentages of smoking reported in Phoenix (80.1 percent), Los Angeles (78.1 percent), and San Diego (74.3 percent). St. Louis and Texas had the largest proportions of methamphetamine admissions who injected the drug (at 34.9 and 35.8 percent of total admissions, respectively), while the highest percentages reporting inhalation as the primary route of methamphetamine administration were in Maine, at approximately 52 percent, followed remotely by Denver (14.8 percent) and New York City (13.6

percent) (table 18). It should be noted that because numbers of primary methamphetamine admissions were relatively small in Boston and Maine, caution should be used in interpreting route of administration data.

**Gender of Methamphetamine Admissions.** In 11 of 15 CEWG areas reporting on the gender of primary methamphetamine admissions, males represented the majority. The largest proportions of male methamphetamine admissions were in Boston and New York City, at approximately 94 percent each, followed by Miami/Dade County, at approximately 82 percent. In 4 of 15 areas (Atlanta, Phoenix, St. Louis, and Texas), females predominated among primary methamphetamine admissions, representing 58.2, 61.1, 51.9, and 55.7 percent of treatment admissions, respectively (table 19).

**Age of Methamphetamine Admissions.** In the 15 CEWG areas for which age of methamphetamine admissions was reported, the majority of methamphetamine admissions were age 35 or older in 3 CEWG areas—Boston, New York City, and San Diego (57.1, 56.8, and 50.6 percent, respectively). Miami/Dade County had the highest proportions of methamphetamine admissions age 25 and younger (83.6 percent), followed distantly by Maryland, at 31.9 percent, and Maine, at 30.3 percent. It should be noted, however, that the total numbers of such admissions were relatively small for Miami/Dade County, Maryland, and Maine. New York City had relatively low percentages of young methamphetamine treatment admissions (fewer than 12 percent were age 25 and younger) (table 19).

**Table 17. Primary Methamphetamine Treatment Admissions in 17 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions<sup>1</sup>: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas <sup>4</sup>	Primary Methamphetamine Admissions	Total Admissions with Primary Alcohol Admissions Excluded <sup>5</sup>		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
<b>FY 2009</b>					
San Francisco	5,527	22,652	24.4	32,141	17.2
<b>CY 2009</b>					
Atlanta	459	4,830	9.5	9,333	4.9
Boston	35	13,392	0.3	19,638	0.2
Colorado	4,123	16,470	25.0	28,510	14.5
Denver	1,373	7,350	18.7	11,947	11.5
Hawaii <sup>6</sup>	3,747	7,229	51.8	8,930	42.0
Los Angeles	9,399	40,916	23.0	53,036	17.7
Maine	33	8,017	0.4	14,498	0.2
Maryland	47	40,638	0.1	60,404	0.1
Miami/Dade County	55	4,253	1.3	5,542	1.0
Minneapolis/St. Paul	1,129	9,961	11.3	20,645	5.5
New York City	206	59,980	0.3	83,401	0.2
Phoenix <sup>7</sup>	941	2,906	32.4	4,481	21.0
St. Louis	295	7,499	3.9	11,677	2.5
San Diego	4,170	11,284	37.0	14,258	29.2
Seattle	901	7,560	11.9	12,986	6.9
Texas <sup>6</sup>	7,535	65,784	11.5	91,072	8.3

<sup>1</sup>More information on these data is available in the footnotes and notes for appendix table 1.<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for calendar year 2009: January–December 2009.<sup>4</sup>Data for five CEWG areas—Baltimore, Cincinnati, Detroit, Broward County, and Philadelphia—were excluded from this table due to small numbers (fewer than 30 total primary methamphetamine treatment admissions). For further information, see appendix table 1.<sup>5</sup>Percentages of primary methamphetamine admissions were obtained from admissions with primary alcohol admissions excluded for comparability with past data.<sup>6</sup>Hawaii reported combined methamphetamine and stimulants admissions. Texas reported combined methamphetamine and amphetamine admissions.<sup>7</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports

**Table 18. Primary Route of Administration of Methamphetamine Among Treatment Admissions in 14 CEWG Areas as a Percentage<sup>1</sup> of Primary Methamphetamine Treatment Admissions: CY 2009<sup>2</sup>**

CEWG Areas <sup>3</sup>	Smoked		Inhaled		Injected		Oral/Other/ Unknown		Total N
	#	%	#	%	#	%	#	%	
Atlanta	261	56.9	55	12.0	85	18.5	58	12.6	459
Boston <sup>4</sup>	19	54.3	-- <sup>4</sup>	--	8	22.9	-- <sup>4</sup>	--	35
Colorado	2,656	64.4	501	12.2	878	21.3	88	2.1	4,123
Denver	806	58.7	203	14.8	323	23.5	41	3.0	1,373
Los Angeles	7,341	78.1	1,136	12.1	675	7.2	247	2.6	9,399
Maine	7	21.2	17	51.5	3	9.1	6	18.2	33
Maryland	14	29.8	3	6.4	3	6.4	27	57.4	47
Miami/Dade County	49	89.1	3	5.5	0	0.0	3	5.5	55
Minneapolis/ St. Paul	819	72.5	74	6.6	169	15.0	67	5.9	1,129
New York City	108	52.4	28	13.6	47	22.8	23	11.2	206
Phoenix <sup>5</sup>	754	80.1	64	6.8	103	10.9	20	2.1	941
St. Louis	152	51.5	28	9.5	103	34.9	12	4.1	295
San Diego	3,099	74.3	355	8.5	663	15.9	53	1.3	4,170
Texas <sup>6</sup>	3,713	49.3	544	7.2	2,700	35.8	578	7.7	7,535

<sup>1</sup>Percentages may not sum to 100 due to rounding.<sup>2</sup>Data are for CY 2009: January–December 2009.<sup>3</sup>No data were available for Cincinnati, Hawaii, San Francisco, and Seattle, while cases reported in Baltimore, Detroit, Broward County, and Philadelphia were not included here due to small numbers. For further information, see appendix table 1.<sup>4</sup>It is Boston Substance Abuse Services (BSAS) policy to suppress (\*) cell counts when they are five or less to preserve confidentiality; consequently their cell totals may not add to the overall totals.<sup>5</sup>Treatment data for Phoenix do not include admissions younger than age 18.<sup>6</sup>Texas reported combined methamphetamine and amphetamine admissions.

SOURCE: June 2010 State and local CEWG reports



**Table 19. Demographic Characteristics of Primary Methamphetamine Treatment Admissions in 15 CEWG Areas, by Percent<sup>1</sup>: CY 2009<sup>2</sup>**

CEWG Areas <sup>3</sup>	Gender		Age Group	
	Percent Male	Percent Female	Percent 25 and Younger	Percent 35 or Older
CY 2009				
Atlanta	41.8	58.2	26.1	35.1
Boston <sup>4</sup>	94.3	-- <sup>4</sup>	22.9	57.1
Colorado	55.1	45.0	23.1	37.9
Denver	55.6	44.4	22.1	38.0
Los Angeles	54.8	45.2	28.1	35.7
Maine	66.7	33.3	30.3	39.4
Maryland	76.6	23.4	31.9	29.8
Miami/Dade County	81.8	18.2	83.6	9.1
Minneapolis/St. Paul	63.7	36.3	26.8	37.8
New York City	94.2	5.8	11.7	56.8
Phoenix	38.9	61.1	23.8 <sup>5</sup>	41.0
St. Louis	48.1	51.9	22.0	42.0
San Diego	53.1	46.9	18.9	50.6
Seattle	57.2	42.8	20.5	28.0 <sup>6</sup>
Texas <sup>7</sup>	44.3	55.7	21.9	39.5

<sup>1</sup>Percentages are rounded to the first decimal place.<sup>2</sup>Data are for calendar year 2009: January–December 2009.<sup>3</sup>Data were not available for San Francisco and Seattle, and cases reported in Baltimore, Cincinnati, Detroit, Broward County, and Philadelphia were not included here due to small numbers. For further information, see appendix table 1.<sup>4</sup>It is Boston Substance Abuse Services (BSAS) policy to suppress (\*) cell counts when they are five or less to preserve confidentiality; consequently their cell totals may not add to the overall totals.<sup>5</sup>Treatment data for Phoenix do not include admissions younger than age 18.<sup>6</sup>Data from Seattle are for age 40 and older.<sup>7</sup>Texas reported combined methamphetamine and amphetamine admissions.

SOURCE: June 2010 State and local CEWG reports

## Changes in Methamphetamine Admissions, 2005–2009

Table 20 compares percentages of primary methamphetamine treatment admissions, excluding primary alcohol admissions, for nine CEWG areas for which data were available from 2005 through 2009. All areas showed declines in methamphetamine admissions over time. The largest percentage-point decrease in methamphetamine-related primary admissions over the 5-year period was in Phoenix, at 16.4 percentage points. San Diego and Minneapolis/St. Paul saw declines in methamphetamine admissions of 13.2 and 10.8 percentage points, respectively, over the period.

In the more recent period from 2008 through 2009, seven of the nine reporting areas had decreases in primary methamphetamine treatment admissions. Phoenix showed the largest decline in methamphetamine admissions (4.6 percentage points) from 2008

to 2009, followed by Seattle, with a decrease of 3.0 percentage points. Two areas, Hawaii and Atlanta, showed increases in methamphetamine admissions of 1.8 and 0.2 percentage points, respectively, during the 2-year period. The decline in St. Louis methamphetamine admissions was negligible, at 0.1 percentage point (table 20).

## Forensic Laboratory Data on Methamphetamine

In 2009, forensic laboratory data for CEWG reporting areas (figure 25 and on the map in section II, figure 22) show that methamphetamine was the drug identified most frequently in Honolulu (38.6 percent of total drug items). Items containing methamphetamine were next most frequently identified among total drug items in Minneapolis/St. Paul (24.4 percent), San Francisco (21.7 percent), Atlanta (20.7 percent), San

**Table 20. Primary Methamphetamine Treatment Admissions in Nine CEWG Reporting Areas, as a Percentage of Primary Drug Admissions, Excluding Primary Alcohol Admissions, and with Percentage-Point Changes for Two Time Periods: 2005–2009 and 2008–2009<sup>1</sup>**

CEWG Area/State	Year (in Percent)					Percentage-Point Change	
	2005	2006 <sup>2</sup>	2007	2008	2009	2005–2009	2008–2009
Atlanta	15.5	11.4	12.5	9.3	9.5	-6.0	+0.2
Denver	20.7	21.4	21.7	20.5	18.7	-2.0	-1.8
Hawaii <sup>3</sup>	56.3	54.3	53.1	50.0	51.8	-4.5	+1.8
Los Angeles	31.4	29.7 <sup>4</sup>	28.2	24.2	23.0	-8.4	-1.2
Minneapolis/St. Paul	22.1	15.4	13.7	12.1	11.3	-10.8	-0.8
Phoenix	48.8	42.4	43.3	37.0	32.4	-16.4	-4.6
St. Louis	5.7	4.0	3.9	4.0	3.9	-1.8	-0.1
San Diego	50.2	47.0 <sup>5</sup>	44.3	38.5	37.0	-13.2	-1.5
Seattle	16.9	17.6	17.3	14.9	11.9	-5.0	-3.0

<sup>1</sup>Calendar year data are reported for all years and areas with exceptions noted below.

<sup>2</sup>Atlanta, Los Angeles, and San Diego reported first half of CY 2006 (January–June) data; all other areas reported full year CY 2006 data.

<sup>3</sup>Hawaii reported combined methamphetamine and stimulants admissions.

<sup>4</sup>This is an updated figure for Los Angeles provided by the CEWG representative to replace the figure of 31.0 percent for CY 2006.

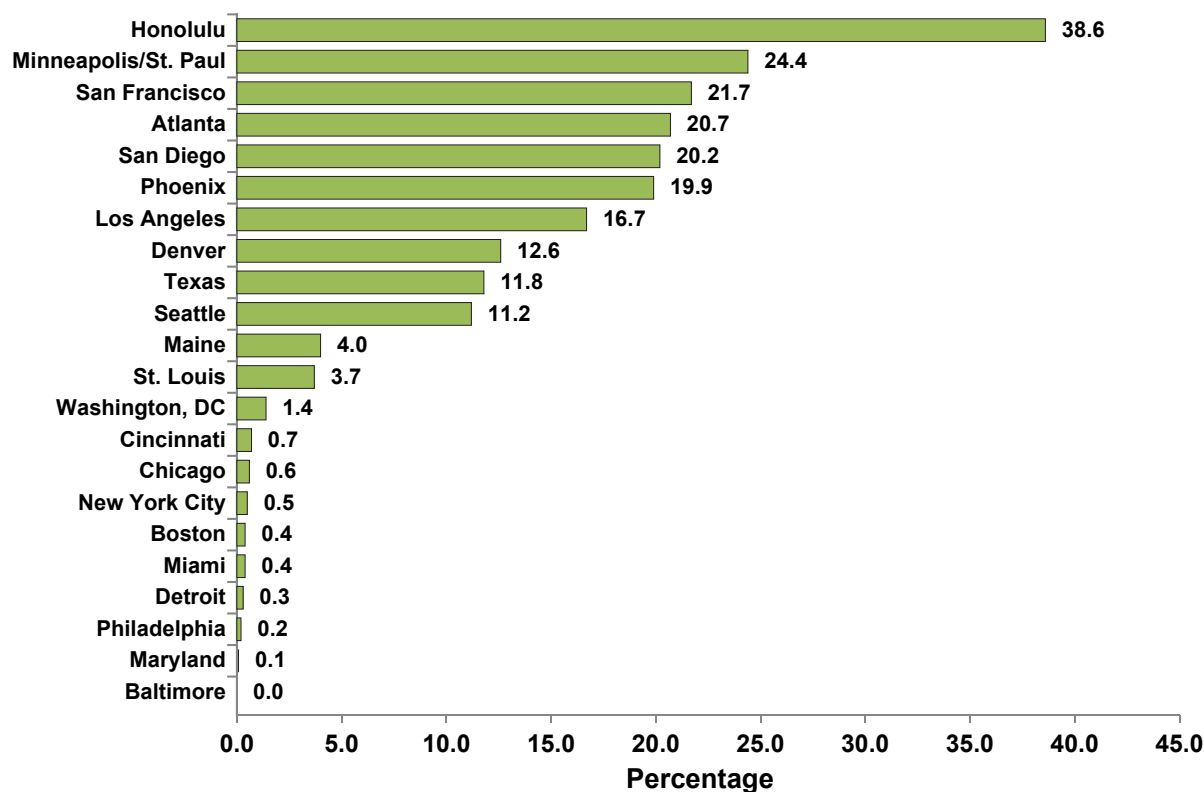
<sup>5</sup>This is an updated figure for San Diego provided by the CEWG representative to replace the figure of 49.0 percent for the first half of CY 2006.

SOURCES: June 2010 State and local CEWG reports; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 67; *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 72; *June 2007 Highlights and Executive Summary Volume I* CEWG report, p. 45; *June 2006 Highlights and Executive Summary Volume I* CEWG report, p. 36; and updates in January 2009 for Los Angeles and San Diego

Diego (20.2 percent), and Phoenix (19.9 percent) (figure 25). In 10 of the CEWG reporting areas, less than 2 percent of the total drug items contained methamphetamine; all were in areas east of the Mississippi River (figure 25; section II, figure 22; appendix table 2).

Methamphetamine ranked first in drug items identified in Honolulu; second in Atlanta, Minneapolis/St. Paul, Phoenix, and San Diego; and third in five CEWG areas—Denver, Los Angeles, San Francisco, Seattle, and Texas in this reporting period (section II, table 2).

**Figure 25. Methamphetamine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: CY 2009<sup>1</sup>**



<sup>1</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

SOURCE: NFLIS, DEA, data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010; see appendix tables 2.1–2.22.

## Marijuana/Cannabis

- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in 2009 in Miami/Dade County (38.2 percent) and Broward County (35.8 percent), followed by Hawaii (28.7 percent), Philadelphia (25.7 percent), and New York City (25.0 percent). The lowest proportions of such admissions were in Boston (4.4 percent) (table 21; appendix table 1).
- Marijuana ranked 1st as the primary drug problem in total drug admissions, including alcohol admissions, in 4 of 22 CEWG areas; these were Miami/Dade and Broward Counties, Philadelphia, and Los Angeles. Marijuana ranked second among primary drugs of admission in eight additional areas: Atlanta, Cincinnati, Minneapolis/St. Paul, Denver, Seattle, and the States of Colorado, Hawaii, and Texas (section II, table 3).
- Increases in percentages of primary marijuana treatment admissions, excluding primary alcohol admissions, were found in 11 of 14 reporting CEWG areas between 2008 and 2009, although only 2 areas (Seattle and Los Angeles) had increases approaching or exceeding 5 percentage points. However, over the 5 years from 2005 to 2009, primary marijuana treatment admissions increased in 12 of 14 reporting areas, with the largest increases noted for Los Angeles, San Diego, and New York City (at 11.2, 9.8, and 9.5 percentage points, respectively) (table 23). Increases of between 5 and 8 percentage points were observed in Atlanta, Detroit, Hawaii, Minneapolis/St. Paul, Phoenix, Seattle, and Texas from 2005 to 2009. Declines in marijuana admissions were observed for two areas over the 5-year period, the largest by far being that for Maine, at approximately 9 percentage points. The other area showing a slight decline in marijuana treatment admissions was Baltimore (at less than 1 percentage point) (table 23).
- Cannabis/marijuana ranked in either first or second place in frequency in the proportion of drug items identified in forensic laboratories in 2009 in all CEWG areas, with the exception of Maine and Atlanta. Cannabis ranked in 1st place among identified drugs in 14 of 22 CEWG areas in this reporting period: Baltimore, Maryland, Philadelphia, Detroit, Chicago, St. Louis, Cincinnati, Minneapolis/St. Paul, Los Angeles, Phoenix, San Diego, San Francisco, Seattle, and Texas. It ranked second in the remaining six areas (section II, table 2). The highest proportions of marijuana items identified in the NFLIS system were in Chicago and San Diego, at approximately 58 and 52 percent, respectively (figure 26; appendix table 2).

### Treatment Admissions Data on Marijuana

In the 2009 reporting period, marijuana/cannabis ranked as the most frequently reported drug by primary treatment admissions in 4 of the 22 CEWG reporting areas, when primary alcohol admissions were included in the total (section II, table 3); these were Miami/Dade and Broward Counties, Philadelphia, and Los Angeles. Marijuana ranked second among primary drugs of admission in eight areas (Atlanta, Cincinnati, Minneapolis/St. Paul,

Denver, Colorado, Hawaii, Seattle, and Texas) (section II, table 3).

As shown in table 21, Miami/Dade County had the highest percentage of primary marijuana treatment admissions, including primary alcohol admissions, at 38.2 percent, followed closely by Broward County at 35.8 percent (also see appendix table 1). The lowest proportion of marijuana treatment admissions was reported in Boston, at 4.4 percent, which was attributed by the area representative to changes in Massachusetts marijuana laws.

**Table 21. Primary Marijuana Treatment Admissions in 22 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions<sup>1</sup>: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas	Primary Marijuana Admissions	Total Admissions with Primary Alcohol Admissions Excluded <sup>4</sup>		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
<b>FY 2009</b>					
Cincinnati	1,532	3,704	41.4	5,480	28.0
San Francisco	3,226	22,652	14.2	32,141	10.0
<b>CY 2009</b>					
Atlanta	1,722	4,830	35.7	9,333	18.5
Baltimore	2,170	14,478	15.0	17,397	12.5
Boston	863	13,392	6.4	19,638	4.4
Colorado	6,160	16,470	37.4	28,510	21.6
Denver	2,787	7,350	37.9	11,947	23.3
Detroit	1,396	6,643	21.0	9,368	14.9
Hawaii	2,562	7,229	35.4	8,930	28.7
Los Angeles	12,222	40,916	29.9	53,036	23.0
Maine	1,303	8,017	16.3	14,498	9.0
Maryland	10,911	40,638	26.8	60,404	18.1
Broward County	2,030	4,424	45.9	5,678	35.8
Miami/Dade County	2,118	4,253	49.8	5,542	38.2
Minneapolis/St. Paul	3,744	9,961	37.6	20,645	18.1
New York City	20,876	59,980	34.8	83,401	25.0
Philadelphia	3,826	11,375	33.6	14,864	25.7
Phoenix <sup>5</sup>	667	2,906	23.0	4,481	14.9
St. Louis	2,492	7,499	33.2	11,677	21.3
San Diego	2,839	11,284	25.2	14,258	19.9
Seattle	2,392	7,560	31.6	12,986	18.4
Texas	21,540	65,784	32.7	91,072	23.7

<sup>1</sup>More information on these data is available in the footnotes and notes for appendix table 1.<sup>2</sup>Data are for the fiscal year 2009: July 2008–June 2009.<sup>3</sup>Data are for the calendar year 2009: January–December 2009.<sup>4</sup>Percentages of primary marijuana admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.<sup>5</sup>Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports

**Gender of Marijuana Admissions.** Males predominated in all 20 CEWG areas reporting on the gender of primary marijuana admissions in 2009 (table 22). The proportion of males ranged from highs of 82.9 and 82.3 percent of marijuana admissions in Philadelphia and Boston,

respectively, to lows of 67.0 percent in Detroit and 64.2 percent in Phoenix.

**Age of Marijuana Admissions.** Across 16 of the 20 CEWG areas for which age distributions were reported, the majority of primary marijuana treatment admissions were age 25 and

**Table 22. Demographic Characteristics of Primary Marijuana Treatment Admissions in 20 CEWG Areas, as a Percentage<sup>1</sup>: FY 2009<sup>2</sup> and CY 2009<sup>3</sup>**

CEWG Areas	Gender		Age Group <sup>4</sup>			
	Percent Male	Percent Female	Percent ≤ 17	Percent 18–25	Percent 26–34	Percent 35 or Older
FY 2009						
Cincinnati	70.4	29.6	37.4	29.0	19.5	14.0
CY 2009						
Atlanta	67.2	32.8	24.6	38.3	22.1	14.9
Baltimore	81.4	18.6	39.7	28.5	20.4	11.4
Boston	82.3	17.7	8.5	39.5	28.3	23.5
Colorado	77.3	22.7	29.6	33.1	22.1	15.1
Denver	77.5	22.5	34.2	31.0	21.2	13.6
Detroit	67.0	33.0	31.7	27.4	23.1	17.8
Los Angeles	68.4	31.6	57.4	20.1	10.4	12.1
Maine	72.4	27.6	29.7	31.3	20.6	18.3
Maryland	79.4	20.6	35.1	39.3	16.4	9.2
Broward County	80.6	19.4	42.2	34.7	13.5	9.6
Miami/Dade County	74.9	25.1	57.3	21.7	12.2	8.8
Minneapolis/St. Paul	79.2	20.8	29.1	38.2	18.8	14.0
New York City	77.4	22.6	10.4	37.2	29.5	22.9
Philadelphia	82.9	17.1	2.0	34.9	34.7 <sup>5</sup>	28.4 <sup>5</sup>
Phoenix	64.2	35.8	— <sup>6</sup>	47.7	31.2	21.1
St. Louis	77.0	23.0	25.4	30.2	26.0	18.5
San Diego	74.4	25.6	55.2	21.5	13.1	10.2
Seattle	74.3	25.7	44.9	27.8	18.5 <sup>7</sup>	8.7 <sup>7</sup>
Texas	71.0	29.0	30.6	36.8	21.6	11.0

<sup>1</sup>Percentages are rounded to one decimal place.

<sup>2</sup>Data are for fiscal year 2009: July 2008–June 2009.

<sup>3</sup>Data are for calendar year 2009: January–December 2009.

<sup>4</sup>Percentages may not add to 100 percent due to the presence of unknown age.

<sup>5</sup>The age ranges are 26–35 and 36 and older for Philadelphia.

<sup>6</sup>Treatment data for Phoenix do not include admissions younger than 18 years of age; therefore, reports of treatment admissions for persons under 18 do not apply to Phoenix.

<sup>7</sup>The age ranges are 26–39 and 40 and older for Seattle.

SOURCE: June 2010 State and local CEWG reports



younger. Exceptions were Boston, New York City, Philadelphia, and Phoenix. Los Angeles, Miami/Dade County, and San Diego had the highest proportions of primary marijuana treatment admissions who were younger than 18, at more than one-half (57.4, 57.3, and 55.2 percent, respectively). Phoenix (47.7 percent), Boston (39.5 percent), and Maryland (39.3 percent) had the highest proportions of marijuana admissions in the next youngest age group, 18–25. Older primary marijuana treatment admissions (age 35 and older) were highest in Philadelphia, at 28.4 percent,

followed by Boston, New York City, and Phoenix, at approximately 21 to 23.5 percent (table 22).

### Changes in Marijuana Admissions, 2005–2009

Table 23 compares percentages of primary marijuana treatment admissions, excluding primary alcohol admissions, for 14 CEWG areas for which data were available from 2005 through 2009. Over the 5-year period, primary marijuana treatment admissions decreased as a percentage of total

**Table 23. Primary Marijuana Treatment Admissions in 14 CEWG Areas by Percentage of All Admissions, Excluding Primary Alcohol Admissions, and Percentage-Point Changes for Two Time Periods: 2005–2009 and 2008–2009**

CEWG Area/State	Year (in Percent)					Percentage-Point Change	
	2005 <sup>1</sup>	2006 <sup>2</sup>	2007 <sup>3</sup>	2008 <sup>3</sup>	2009 <sup>3</sup>	2005–2009	2008–2009
Atlanta	27.7	30.9	31.4	33.1	35.7	+8.0	+2.6
Baltimore	15.8	18.3	12.8	13.4	15.0	-0.8	+1.6
Denver	37.0	36.9	36.6	38.1	37.9	+0.9	-0.2
Detroit	15.4	19.0	20.8	19.2	21.0	+5.6	+1.8
Hawaii	29.2	29.6	32.3	34.9	35.4	+6.2	+0.5
Los Angeles	18.7	20.2 <sup>4</sup>	22.5	25.2	29.9	+11.2	+4.7
Maine	25.6	21.7	20.5	17.8	16.3	-9.3	-1.5
Minneapolis/ St. Paul	32.6	35.5	32.8	35.0	37.6	+5.0	+2.6
New York City	25.3	27.8	29.3	32.2	34.8	+9.5	+2.6
Phoenix	16.0	18.6	19.9	21.2	23.0	+7.0	+1.8
St. Louis	29.0	27.5	31.5	35.8	33.2	+4.2	-2.6
San Diego	15.4	18.4 <sup>5</sup>	19.5	23.6	25.2	+9.8	+1.6
Seattle	25.2	24.4	25.5	25.6	31.6	+6.4	+6.0
Texas	27.1	28.7	30.2	31.2	32.7	+5.6	+1.5

<sup>1</sup>Detroit reported FY 2005 (July 2004–June 2005) data; all others reported full year CY 2005 data.

<sup>2</sup>Detroit reported FY 2006 (July 2005–June 2006) data; Atlanta and San Diego reported first half CY 2006 (January–June 2006) data; all others reported full year CY 2006 data.

<sup>3</sup>Calendar year (January–December) data.

<sup>4</sup>The Los Angeles representative provided updated data for CY 2006, replacing the previous value of 19.7 percent for the first half of 2006.

<sup>5</sup>The San Diego representative provided updated data for CY 2006, replacing the previous value of 16.6 percent for the first half of CY 2006.

SOURCES: June 2010 State and local CEWG reports; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 74; *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 72; and *June 2007 Highlights and Executive Summary Volume I* CEWG report, p. 51; *June 2006 Highlights and Executive Summary Volume I* CEWG report, p. 29; and updates in January 2009 for Los Angeles and San Diego

nonalcohol admissions in two areas (Maine and Baltimore), with declines of 9.3 and 0.8 percentage points, respectively. Conversely, 2005–2009 proportions of primary marijuana admissions increased in the remaining 12 areas. The largest increases were found for Los Angeles, San Diego, New York City, and Atlanta, at 11.2, 9.8, 9.5, and 8.0 percentage points, respectively. Increases of 4–7 percentage points were recorded for Detroit, Hawaii, Minneapolis/St. Paul, Phoenix, Seattle, St. Louis, and Texas, while Denver had an increase of less than 1 percentage point (table 23).

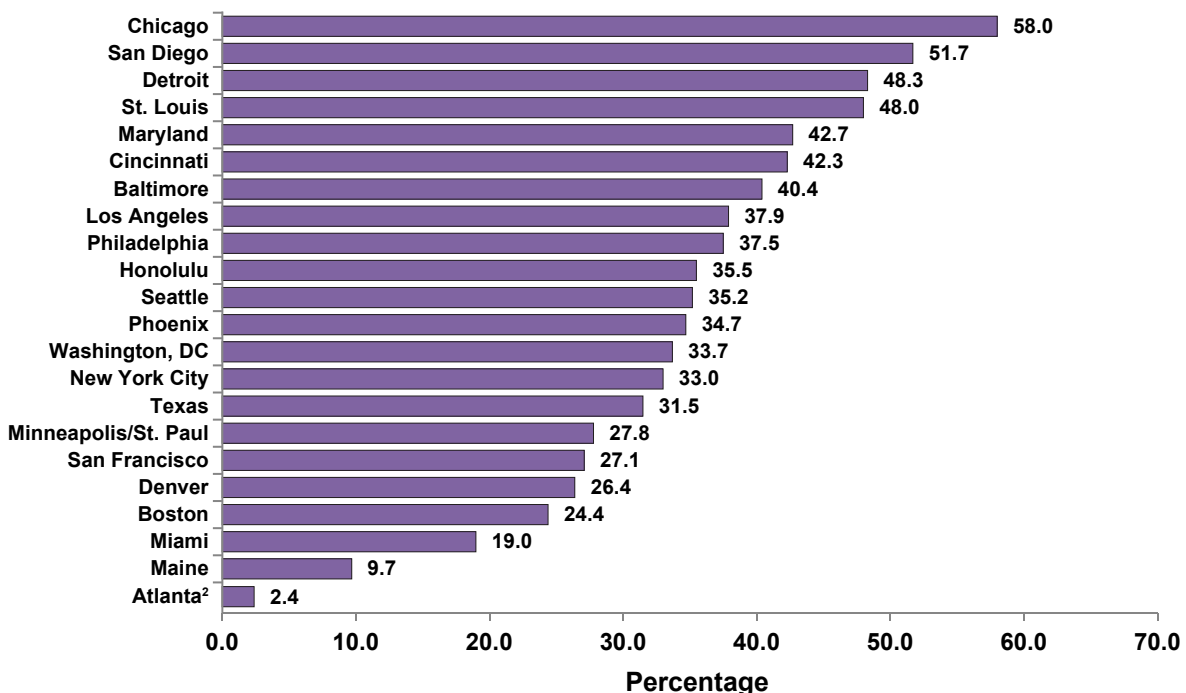
In the more recent period from 2008 through 2009, increases in marijuana admissions were observed for 11 of 14 reporting areas, with declines for Denver (0.2 percentage points), Maine (1.5 percentage points), and St. Louis (2.6 percentage points). The largest increases in the 2-year period were for Seattle, at 6 percentage points, and Los Angeles, at 4.7 percentage points. Increases of less than 3 percentage points were found in the remaining 9 of 14 CEWG reporting areas (table 23).

## Forensic Laboratory Data on Marijuana/Cannabis

Chicago had the highest percentage of marijuana/cannabis identified by NFLIS laboratories in 2009 (58.0 percent), followed by San Diego, Detroit, and St. Louis (51.7, 48.3, and 48.0 percent, respectively) (figure 26; appendix table 2). The proportions of cannabis drug items identified in the other 19 CEWG areas were highest in Maryland (42.7 percent), Cincinnati (42.3 percent), and Baltimore (40.4 percent). The remaining CEWG sites had percentages ranging from 2.4 percent in Atlanta<sup>22</sup> to 37.9 percent in Los Angeles for cannabis drug items identified (figure 26).

Cannabis ranked in either first or second place among drug items most frequently identified in all but two CEWG areas; the exceptions are Maine and Atlanta, where it ranked third and seventh, respectively. In 2009, cannabis ranked in 1st place among identified drugs in 14 of 22 CEWG areas: Baltimore, Maryland, Philadelphia, Detroit, Chicago, St. Louis, Cincinnati, Minneapolis/St. Paul, Los Angeles, Phoenix, San Diego, San Francisco, Seattle, and Texas. It was the second most frequently identified drug item in 2009 NFLIS data in another six CEWG areas (section II, table 2).

**Figure 26. Cannabis/THC Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: CY 2009<sup>1</sup>**



<sup>1</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

<sup>2</sup>In 2004, Georgia initiated a statewide administrative policy that when cannabis is seized by law enforcement officers, laboratory testing is not required. This results in artificially low numbers of such drug items identified in the CEWG area relative to other CEWG areas.

SOURCE: NFLIS, DEA, data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010; see appendix tables 2.1–2.22

<sup>22</sup>In 2004, Georgia initiated a statewide administrative policy that laboratory testing is not required when cannabis is seized by law enforcement officers. This results in artificially low numbers of such drug items identified in this CEWG area relative to other CEWG areas.

## Club Drugs (MDMA, MDA, GHB, LSD, and Ketamine)

### Treatment Admissions Data on Club Drugs

The club drugs reported on in this section include MDMA or ecstasy, MDA, GHB, LSD, and ketamine. Admissions for primary treatment of club drugs or MDMA are not captured in all treatment data systems, but they appear low in those areas that do report on these drugs.

### Forensic Laboratory Data on Club Drugs

**MDMA.** MDMA was the club drug most frequently reported among NFLIS data in the 22 CEWG areas depicted in table 24. As shown, MDMA equaled or exceeded 2 percent of all drug items in seven areas. These include Minneapolis/St. Paul and San Francisco, which had the highest percentages (4.7 and 4.2 percent, respectively). Other areas whose MDMA NFLIS items equaled 2 percent or greater were Maine (3.2 percent), Los Angeles (2.9 percent), Denver (2.7 percent), Seattle (2.5 percent), and Atlanta (2.0 percent). As shown in section II, table 2, MDMA was the fourth most frequently identified drug item in Chicago and Minneapolis/St. Paul in 2009. It ranked 5th in 5 of 22 reporting areas: Detroit, Denver, Honolulu, Los Angeles, and San Francisco (section II, table 2).

**MDA.** MDA was reported among the drug items identified in 8 of 22 areas in 2009: Atlanta, Denver, Honolulu, New York City, Philadelphia, San Diego, San Francisco, and Seattle, although numbers were low in all cases (table 25).

**GHB.** GHB drug items were reported in 7 CEWG areas of the 22 reporting, including Atlanta, Chicago, Los Angeles, New York City, San Diego, San Francisco, and Texas in 2009. Again, numbers were very low, from 1 to 92 (table 25).

**LSD.** LSD was not among the top 10 drugs reported in the NFLIS system for any CEWG reporting area, but it was reported in all but 4 of the 22 CEWG areas. These four exceptions are Detroit, Honolulu, Minneapolis/St. Paul, and Washington, DC. Numbers ranged from 2 to 59. Only 1 area, Texas, had 30 or more drug items, and in no area did the proportion reach 1 percent of drug items identified (table 25).

**Ketamine.** Ketamine was identified among drug items in the NFLIS system in 2009 in 18 of 22 areas, in all but Boston, Honolulu, Minneapolis/St. Paul, and St. Louis. While ketamine represented less than 1 percent of total drug items identified in any reporting area, 4 areas reported 30 cases or more: Texas, New York City, San Francisco, and Los Angeles (table 25). Ketamine did not figure among the top 10 most frequently identified drug items in any CEWG area (section II, table 2).

**Table 24. Number of MDMA Items Identified and MDMA Items as a Percentage of Total Items Identified by Forensic Laboratories in 22 CEWG Areas: 2009<sup>1</sup>**

CEWG Area	MDMA Items	Total Items Identified	Percentage of Total Items Identified
Atlanta	236	11,557	2.0
Baltimore	161	50,870	0.3
Boston	124	17,394	0.7
Chicago	1,314	81,383	1.6
Cincinnati	167	12,497	1.3
Denver	204	7,676	2.7
Detroit	164	10,121	1.6
Honolulu	17	1,594	1.1
Los Angeles	1,358	46,300	2.9
Maine	27	832	3.2
Maryland	184	55,149	0.3
Miami	356	24,772	1.4
Minneapolis/St. Paul	212	4,483	4.7
New York City	910	52,677	1.7
Philadelphia	79	34,929	0.2
Phoenix	91	6,369	1.4
St. Louis	219	17,851	1.2
San Diego	396	20,941	1.9
San Francisco	658	15,659	4.2
Seattle	66	2,618	2.5
Texas	1,910	103,085	1.9
Washington, DC	25	3,520	0.7

<sup>1</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

SOURCE: NFLIS, DEA, data for Atlanta, Baltimore, Boston, Chicago, Miami, St. Louis, and San Francisco were retrieved on April 24, 2010; data for all other areas were retrieved on April 26, 2010; see appendix 2.1–2.22; data are subject to change and may differ according to the date on which they were queried

**Table 25. Number of MDA, GHB, Ketamine, LSD, PCP, and Selected Other Drug Items<sup>1</sup> Identified by Forensic Laboratories, in 22 CEWG Areas: 2009<sup>2</sup>**

CEWG Area	MDA	GHB	PCP	LSD	Psilocin <sup>3</sup>	Ketamine	BZP	Cariso-prodol	Totals
Atlanta	8	1	--	12	39	10	31	109	11,557
Baltimore	--	--	95	4	28	4	113	--	50,870
Boston	--	--	15	11	40	--	58	22	17,394
Chicago	--	11	215	26	146	28	1,188	6	81,383
Cincinnati	--	--	--	8	30	4	156	1	12,497
Denver	15	--	--	4	93	6	128	3	7,676
Detroit	--	--	--	--	8	2	144	1	10,121
Honolulu	5	--	--	--	--	--	8	4	1,594
Los Angeles	--	30	469	19	153	42	160	171	46,300
Maine	--	--	--	6	12	2	14	--	832
Maryland	--	--	176	6	32	7	126	--	55,149
Miami	--	--	-- <sup>4</sup>	5	9	23	136	19	24,772
Minneapolis/ St. Paul	--	--	--	--	56	--	25	5	4,483
New York City	26	6	609	14	14	291	250	--	52,677
Philadelphia	5	--	907	2	8	3	51	--	34,929
Phoenix	--	--	10	3	27	9	18	63	6,369
St. Louis	--	--	19	21	51	--	419	10	17,851
San Diego	5	5	47	6	75	10	52	14	20,941
San Francisco	5	6	12	14	89	41	4	16	15,659
Seattle	1	--	24	2	19	1	62	--	2,618
Texas	--	92	361	59	234	84	1,565	1,081	103,085
Washington, DC	--	--	209	--	--	1	63	--	3,520

<sup>1</sup>Data for BZP are also reported in section II, table 1 for 21 CEWG areas for which data were comparably reported from 2007 to 2009. TFMPP was found in 250 drug items identified in Texas; 196 in Atlanta; 60 in Chicago; 30 in Washington, DC; 6 in Honolulu; 3 in New York City; 2 in San Francisco; and 1 in Philadelphia in 2009. Drug items containing Foxy Methoxy were identified in Miami ( $n=4$ ) and Denver ( $n=2$ ).

<sup>2</sup>Data are for January–December 2009, except San Francisco, where data are for January–July 2009. Due to reporting difficulties, the drug count for San Francisco is expected to be lower than usual and should not be compared with drug item counts from previous years.

<sup>3</sup>Psilocybine, psilocybin, psilocin and psilocin are grouped together in this table under the category, "Psilocin."

<sup>4</sup>Miami does not report PCP as a separate category, reporting 421 "hallucinogens" identified in 2009.

SOURCE: NFLIS, DEA, data for all areas except Philadelphia were received December 10, 2009; Philadelphia data were received January 28, 2010; see appendix tables 2.1–2.22; data are subject to change and may differ according to the date on which the data were queried



## PCP (Phencyclidine)

### Forensic Laboratory Data on PCP

As a percentage of all identified items, PCP items were highest in Washington, DC, at 5.9 percent, followed by Philadelphia, at 2.6 percent, New York City, at 1.2 percent, and Los Angeles, at 1.0 percent (table 25).

PCP figured among the top 10 most frequently identified drug items in 6 CEWG areas from NFLIS data for 2009. In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in 2009. PCP was also among the top drug items identified in Philadelphia, where it ranked sixth. In 2009, PCP ranked 7th in Los Angeles, 8th in New York

City, 9th in Chicago, and 10th in Maryland (section II, table 2). No PCP items were documented in forensic laboratory data on drug items identified in eight CEWG areas: Atlanta, Cincinnati, Denver, Detroit, Honolulu, Maine, Minneapolis/St. Paul, and Miami. Miami NFLIS reported a general category of hallucinogens, which totaled 421 cases in 2009 (table 25; appendix table 2). Fewer than 30 such items were identified in five areas (Boston, Phoenix, St. Louis, San Francisco, and Seattle). The areas reporting 30 or more PCP items were Baltimore, Chicago, Los Angeles, Maryland, New York City, Philadelphia, San Diego, Texas, and Washington, DC.

## Other Drugs (Including BZP, TFMPP, Foxy Methoxy, Psilocin/Psilocybin, and Carisoprodol)

**BZP (1-Benzylpiperazine)** In 2009, BZP emerged among the identified drugs in NFLIS forensic laboratories in all of the 21 CEWG areas reporting consistent data (section II, tables 1 and 2). This contrasts with 2007, when 10 of the 20 CEWG reporting areas listed BZP-containing drug items among those identified in forensic laboratories, and 2008, when 19 of 21 CEWG areas with comparable data identified BZP in NFLIS data (section II, table 1).

Based on table 25 for 2009, 9 of 22 CEWG areas reported 1 percent or more drug items containing BZP among drug items identified. The highest proportions of this drug were reported in NFLIS data for Seattle and St. Louis, at 2.4 and 2.3 percent, respectively, followed by Washington, DC (1.8 percent), Maine and Denver (1.7 percent), Texas and Chicago (1.5 percent), Detroit (1.4 percent), and Cincinnati (1.2 percent) (table 25; appendix table 2; see section II, footnote 11).

Percentages of BZP drug items identified increased from a high of 0.14 percent in 2007 in Detroit, to 1.6 and 1.7 percent, respectively, in Seattle and Washington, DC, in 2008, to 2.3 and 2.4 percent, respectively, in St. Louis and Seattle in 2009 (section II, table 1).

BZP did not rank in the top 10 drugs identified in NFLIS forensic laboratories in any CEWG reporting area in 2007; however, it was reported in the top 10 in 7 of 21 reporting areas in 2008 and in 11 of 21 reporting areas in 2009 (section II, table 1). BZP ranked higher in more areas in 2009 than 2008. In 2008, BZP ranked 6th in 1 area (Chicago), 7th in 3 areas (Washington, DC, Seattle, and Honolulu), 9th in 1 area (Miami), and 10th in 2 areas (Detroit and Texas). In 2009, BZP ranked 5th in 3 areas (Chicago, St. Louis, and Washington, DC), 6th in 1 (Detroit), 7th in 2 (Denver and Seattle), 8th in 3 (Texas, Cincinnati, and Miami), 9th in Honolulu, and 10th in Maine (section II, tables 1 and 2).

**TFMPP (1-(3-Trifluoromethylphenyl)piperazine)** The identification of this drug in NFLIS data for 2009 was localized to 8 of 22 areas, up from 2 in 2008 (Atlanta and Washington, DC) and 1 area (Atlanta) in 2007. Areas where TFMPP was reported among data items analyzed in 2009 were Texas, Atlanta, Chicago, Washington, DC, Honolulu, New York City, San Francisco, and Philadelphia (table 25, footnote 1). In 2009 forensic laboratory data, TFMPP ranked seventh and ninth in frequency among drug items identified in Washington, DC, and Atlanta, respectively (section II, table 2). In 2008, it ranked eighth in frequency among drug items identified in these same two areas. It should be noted that since TFMPP is not a controlled substance, it may not be reported to NFLIS by forensic laboratories in all areas.

**Foxy Methoxy (5-Methoxy-N,N-Diisopropyltryptamine, or 5-MeO-DIPT)** The only two CEWG areas in which Foxy Methoxy drug items were identified were Miami, with four items containing Foxy reported, and Denver, with two items in 2009 (table 25, footnote 1). Foxy Methoxy was identified in drug items in Denver only in 2008, but 19 items containing it were identified that year. No areas reported Foxy Methoxy items in 2007 in the NFLIS system.

**Psilocin/Psilocybin** Psilocin/psilocybin, a hallucinogen, ranked 9th in Denver and 10th in Minneapolis/St. Paul in the NFLIS data for the current reporting period (section II, table 2). In 2008, psilocin ranked 8th in Denver and 10th in Maine; in 2007, it ranked 10th in Los Angeles among the top 10 items identified (section II, table 2). Psilocin/psilocybin was reported among drug items seized and identified in forensic laboratories in 20 of 22 CEWG areas in 2009; exceptions were Honolulu and Washington, DC (table 25).

**Carisoprodol** Carisoprodol was identified among drug items seized and analyzed in 15 of 22 reporting areas in 2009; it was not identified in 7 areas (Baltimore, Maine, Maryland, New York

City, Philadelphia, Seattle, and Washington, DC) (table 25). In 2009, drug items containing carisoprodol represented 1 percent of identified NFLIS drug items in Texas and Phoenix, and they ranked 9th in Texas and Phoenix and 10th in Atlanta among the 10 most frequently identified items

from 22 CEWG areas (section II, table 2). Carisoprodol ranked in the top 10 drug items identified in these same 3 areas in 2007 (ranking 8th in all 3), and in 2008, it ranked 8th in the top 10 drugs in Texas and Phoenix, and 10th in Atlanta and Los Angeles.

# Appendix Tables

**Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, and CEWG Area: FY 2009<sup>1</sup> and CY 2009<sup>2</sup>**

CEWG Areas	Number of Total Admissions							Total
	Alcohol	Cocaine/ Crack <sup>3</sup>	Heroin	Other Opiates	Meth- amphet- amine	Marijuana	Other Drugs/ Unknown	(N) <sup>4</sup>
FY 2009								
Cincinnati	1,776	673	775 <sup>5</sup>	— <sup>5</sup>	11 <sup>6</sup>	1,532	713	5,480
San Francisco	9,489	6,797	5,686	NR <sup>7</sup>	5,527	3,226	1,416	32,141
CY 2009								
Atlanta	4,503 <sup>8</sup>	1,465	363	484	459	1,722	337	9,333
Baltimore	2,919	2,409	9,137	569	9	2,170	184	17,397
Boston	6,246	1,343	10,025	859	35	863	267 <sup>9</sup>	19,638 <sup>9</sup>
Colorado	12,040	2,660	1,570	1,475	4,123	6,160	482	28,510
Denver	4,597	1,333	960	627	1,373	2,787	270	11,947
Detroit	2,725	1,806	3,211	203	3	1,396	24	9,368
Hawaii	1,701 <sup>8</sup>	335	170	NR <sup>7</sup>	3,747 <sup>6</sup>	2,562	415	8,930
Los Angeles	12,120	6,690	9,978	1,315	9,399	12,222	1,312	53,036
Maine	6,481 <sup>8</sup>	575	1,250	4,185	33	1,303	671	14,498
Maryland	19,766	6,737	16,170	5,476	47	10,911	1,297	60,404
Broward County	1,254	769	105	336	20	2,030	1,164	5,678
Miami/Dade County	1,289	1,557	150	113	55	2,118	260	5,542
Minneapolis/St. Paul	10,684	1,317	1,644	1,722	1,129	3,744	405	20,645
New York City	23,421	13,744	21,931	1,286	206	20,876	1,937	83,401
Philadelphia	3,489	3,182	1,994	513	16	3,826	1,844	14,864
Phoenix <sup>10</sup>	1,575	236	751	184	941	667	127	4,481
St. Louis	4,178	1,585	2,630	313	295	2,492	184	11,677
San Diego	2,974	763	2,763	553	4,170	2,839	196	14,258
Seattle	5,426	1,443	1,538	722	901	2,392	564	12,986
Texas	25,288	16,234	11,368	5,844	7,535 <sup>6</sup>	21,540	3,263	91,072

<sup>1</sup>Data are for fiscal year 2009: July 2008–June 2009.

<sup>2</sup>Data are for calendar year 2009: January–December 2009.

<sup>3</sup>Cocaine values were broken down into crack or powder/other cocaine for the following areas: Atlanta (crack=968; powder or other cocaine=497); Baltimore (crack=2,111; powder or other cocaine=298); Boston (crack=779; powder or other cocaine=564); Detroit (crack=1,663; powder or other cocaine=143); Maine (crack=171; powder or other cocaine=404); Maryland (crack=5,509; powder or other cocaine=1,228); Broward County (crack=610; powder or other cocaine=159); Miami/Dade County (crack=867; powder or other cocaine=690); Minneapolis/St. Paul (crack=281; powder or other cocaine=1,036); New York City (crack=8,390; powder or other cocaine=5,354); Philadelphia (crack=2,415; powder or other cocaine=409; unknown=358); St. Louis (crack=1,407; powder or other cocaine=178); and Texas (crack=9,623; powder or other cocaine=6,611). No breakdowns by type of cocaine were available for Cincinnati, Colorado, Denver, Hawaii, Los Angeles, Phoenix, San Diego, San Francisco, and Seattle.

<sup>4</sup>These *N*'s are used in all percentage calculations involving total treatment admissions data for each area. Treatment data contain unknown primary admissions in Atlanta (*n*=5), Cincinnati (*n*=350), Hawaii (*n*=415), Maine (*n*=470), Broward County (*n*=422), Miami/Dade County (*n*=117), Minneapolis/St. Paul (*n*=120), and New York City (*n*=629). Because these cases may be classified as to route of administration and demographic characteristics, they are included in the numbers for these areas and are included with "Other Drugs/Unknown" in this table. Total admissions data for all other areas exclude unknowns.

<sup>5</sup>Heroin and other opiates are grouped together in Cincinnati treatment data.

<sup>6</sup>Methamphetamine and amphetamine are grouped together in Texas treatment data. Methamphetamine, amphetamine, and MDMA are grouped together in Cincinnati treatment data. Methamphetamine and stimulants are grouped together in Hawaii treatment data.

<sup>7</sup>NR=Not reported by the CEWG area representative.

<sup>8</sup>Alcohol data for Atlanta are alcohol only=1,939 and alcohol in combination with other drugs=4,503. Alcohol only and alcohol in combination are grouped together in Maine treatment data. Hawaii reported data for alcohol in combination, but excluded alcohol only.

<sup>9</sup>Unknowns (*n*=702) are excluded from the "Other Drugs/Unknown" category for Boston and from the total for all drugs in that area. In past reports, this "Other Drug/Unknown" category has included unknowns. This fact makes these numbers noncomparable with data reported in previous reports for Boston.

<sup>10</sup>Phoenix data report total admissions of 8,205, of which 3,724 did not report using any drugs at admission for substance abuse treatment; the *N* of 4,481 includes only cases in which a primary drug was reported. Treatment data were provided by CEWG representatives between May 2010 and July 2010. Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: June 2010 State and local CEWG reports

**Appendix Tables 2.1–2.22. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 22 CEWG Areas: January–December 2009.**
**Appendix Table 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Atlanta: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cocaine	5,624	48.7
Methamphetamine	2,396	20.7
Alprazolam	583	5.0
Oxycodone	524	4.5
Hydrocodone	515	4.5
Heroin	283	2.4
Cannabis	281	2.4
3,4-Methylenedioxy-methamphetamine	236	2.0
1-(3-Trifluoromethyl-phenyl)Piperazine	196	1.7
Carisoprodol	109	0.9
Other <sup>2</sup>	810	7.0
<b>Total</b>	<b>11,557</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data are for the 28-county Atlanta/Sandy Springs/Marietta GA MSA: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 24, 2010

**Appendix Table 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Boston: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cocaine	5,008	28.8
Cannabis	4,249	24.4
Heroin	2,828	16.3
Oxycodone	1,149	6.6
Clonazepam	461	2.7
Buprenorphine	419	2.4
Alprazolam	257	1.5
Hydrocodone	171	1.0
3,4-Methylenedioxy-methamphetamine	124	0.7
Amphetamine	115	0.7
Other <sup>2</sup>	2,613	15.0
<b>Total</b>	<b>17,394</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data include all counties in the Boston MSA: Essex, Middlesex, Norfolk, Plymouth, Rockingham, Strafford, and Suffolk Counties.

2. "No Drug Found" represents 443 cases and are included under "Other."

3. "Noncontrolled Nonnarcotic Drug" represents 276 cases and are included under "Other."

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 24, 2010

**Appendix Table 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Baltimore: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	20,543	40.4
Cocaine	15,209	29.9
Heroin	11,055	21.7
Oxycodone	948	1.9
Buprenorphine	787	1.5
Alprazolam	444	0.9
Clonazepam	237	0.5
Methadone	181	0.4
3,4-Methylenedioxy-methamphetamine	161	0.3
Hydrocodone	137	0.3
Other <sup>2</sup>	1,168	2.3
<b>Total</b>	<b>50,870</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data are for the Baltimore MSA, including Baltimore City and six counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's Counties. There are no reported drug items in 2009 for Harford or Queen Anne Counties.

2. Percentages may not sum to the total due to rounding.

3. "No Drug Found" represents 162 cases and are included under "Other."

SOURCE: NFLIS, DEA, April 24, 2010

**Appendix Table 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Chicago: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	47,212	58.0
Cocaine	17,803	21.9
Heroin	10,671	13.1
3,4-Methylenedioxy-methamphetamine	1,314	1.6
1-Benzylpiperazine	1,188	1.5
Hydrocodone	508	0.6
Methamphetamine	457	0.6
Alprazolam	321	0.4
Phencyclidine	215	0.3
Acetaminophen	186	0.2
Other <sup>2</sup>	1,508	1.9
<b>Total</b>	<b>81,383</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data are for 13 counties in the Chicago/Naperville/Joliet, IL/IN/WI MSA: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, and Will Counties in IL; Jasper, Lake, Newton, and Porter Counties in IN; and Kenosha County in WI.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 24, 2010



**Appendix Table 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Cincinnati: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	5,281	42.3
Cocaine	4,100	32.8
Heroin	1,364	10.9
Oxycodone	404	3.2
Hydrocodone	211	1.7
Alprazolam	168	1.3
3,4-Methylenedioxy-methamphetamine	167	1.3
1-Benzylpiperazine	156	1.2
Methamphetamine	85	0.7
Clonazepam	83	0.7
Other <sup>2</sup>	478	3.8
<b>Total</b>	<b>12,497</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for Hamilton County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Denver: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cocaine	2,685	35.0
Cannabis	2,027	26.4
Methamphetamine	966	12.6
Heroin	483	6.3
3,4-Methylenedioxy-methamphetamine	204	2.7
Oxycodone	152	2.0
1-Benzylpiperazine	128	1.7
Hydrocodone	113	1.5
Psilocin	79	1.0
Alprazolam	61	0.8
Other <sup>2</sup>	778	10.1
<b>Total</b>	<b>7,676</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for Denver, Arapahoe, and Jefferson Counties.

2. "Noncontrolled Nonnarcotic Drug" represents 399 cases and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Detroit: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	4,886	48.3
Cocaine	2,677	26.4
Heroin	1,180	11.7
Hydrocodone	338	3.3
3,4-Methylenedioxy-methamphetamine	164	1.6
1-Benzylpiperazine	144	1.4
Alprazolam	134	1.3
Oxycodone	65	0.6
Methamphetamine	33	0.3
Codeine	28	0.3
Other <sup>2</sup>	472	4.7
<b>Total</b>	<b>10,121</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for Wayne County.

2. "Noncontrolled Nonnarcotic" drugs represent 288 cases and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Honolulu: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Methamphetamine	616	38.6
Cannabis	566	35.5
Cocaine	250	15.7
Heroin	23	1.4
3,4-Methylenedioxy-methamphetamine	17	1.1
Acetaminophen	16	1.0
Oxycodone	15	0.9
Morphine	10	0.6
1-Benzylpiperazine	8	0.5
Alprazolam	8	0.5
Other <sup>2</sup>	65	4.1
<b>Total</b>	<b>1,594</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for Honolulu County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Los Angeles: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	17,532	37.9
Cocaine	12,476	26.9
Methamphetamine	7,720	16.7
Heroin	2,402	5.2
3,4-Methylenedioxy-methamphetamine	1,358	2.9
Hydrocodone	772	1.7
Phencyclidine	469	1.0
Alprazolam	335	0.7
Codeine	199	0.4
Oxycodone	180	0.4
Other <sup>2</sup>	2,857	6.2
<b>Total</b>	<b>46,300</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for Los Angeles County.

2. "No Drug Found" represents 440 cases and are included under "Other."

3. "Noncontrolled Nonnarcotic Drug" represents 225 cases and are included under "Other."

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maryland: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	23,530	42.7
Cocaine	16,165	29.3
Heroin	11,188	20.3
Oxycodone	956	1.7
Buprenorphine	788	1.4
Alprazolam	446	0.8
Clonazepam	238	0.4
3,4-Methylenedioxy-methamphetamine	184	0.3
Methadone	181	0.3
Phencyclidine	176	0.3
Other <sup>2</sup>	1,297	2.4
<b>Total</b>	<b>55,149</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for the State of Maryland; drug item counts exclude the Maryland State Laboratory System data.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maine: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cocaine	352	42.3
Heroin	120	14.4
Cannabis	81	9.7
Oxycodone	61	7.3
Methamphetamine	33	4.0
3,4-Methylenedioxy-methamphetamine	27	3.2
Buprenorphine	20	2.4
Hydrocodone	19	2.3
Methadone	15	1.8
1-Benzylpiperazine	14	1.7
Other <sup>2</sup>	90	10.8
<b>Total</b>	<b>832</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for the State of Maine.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Miami: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cocaine	15,309	61.8
Cannabis	4,699	19.0
Heroin	773	3.1
Alprazolam	568	2.3
Hallucinogen	421	1.7
3,4-Methylenedioxy-methamphetamine	356	1.4
Oxycodone	339	1.4
1-Benzylpiperazine	136	0.5
Methamphetamine	110	0.4
Hydrocodone	65	0.3
Other <sup>2</sup>	1,996	8.1
<b>Total</b>	<b>24,772</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for the Miami/Fort Lauderdale/Pompano Beach MSA and include Broward, Dade, and Palm Beach Counties.

2. "Controlled Substance (Unspecified)" represents 1,044 cases and are included under "Other."

3. "No Drug Found" represents 540 cases and are included under "Other."

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 24, 2010

**Appendix Table 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Minneapolis/ St. Paul: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	1,246	27.8
Methamphetamine	1,095	24.4
Cocaine	997	22.2
3,4-Methylenedioxy-methamphetamine	212	4.7
Heroin	181	4.0
Oxycodone	116	2.6
Hydrocodone	37	0.8
Amphetamine	34	0.8
Alprazolam	32	0.7
Cathinone	29	0.6
Psilocybin/Psilocyn <sup>2</sup>	29	0.6
Other <sup>3</sup>	475	10.6
<b>Total</b>	<b>4,483</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>Cathinone and Psilocybin/Psilocyn are tied for 10<sup>th</sup> place.<sup>3</sup>All other analyzed items.

NOTES:

1. Data are for seven counties in Minnesota: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Philadelphia: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	13,083	37.5
Cocaine	11,691	33.5
Heroin	4,187	12.0
Oxycodone	1,391	4.0
Alprazolam	1,238	3.5
Phencyclidine	907	2.6
Codeine	251	0.7
Clonazepam	238	0.7
Hydrocodone	223	0.6
Buprenorphine	121	0.3
Other <sup>2</sup>	1,599	4.6
<b>Total</b>	<b>34,929</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for Philadelphia County.

2. "Noncontrolled Nonnarcotic Drug" represents 923 cases and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, New York City: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cocaine	21,222	40.3
Cannabis	17,372	33.0
Heroin	6,297	12.0
Alprazolam	1,501	2.8
Oxycodone	1,050	2.0
3,4-Methylenedioxy-methamphetamine	910	1.7
Methadone	645	1.2
Phencyclidine	609	1.2
Hydrocodone	412	0.8
Buprenorphine	340	0.6
Other <sup>2</sup>	2,319	4.4
<b>Total</b>	<b>52,677</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for the New York City Police Department and five New York boroughs: Bronx, Kings, Queens, New York, and Richmond.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Phoenix: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	2,212	34.7
Methamphetamine	1,268	19.9
Cocaine	997	15.7
Heroin	561	8.8
Oxycodone	229	3.6
Hydrocodone	144	2.3
Alprazolam	122	1.9
3,4-Methylenedioxy-methamphetamine	91	1.4
Carisoprodol	63	1.0
Clonazepam	47	0.7
Other <sup>2</sup>	635	10.0
<b>Total</b>	<b>6,369</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for Maricopa County.

2. "Unspecified Prescription Drug" represents 116 cases and are included under "Other."

3. "No Drug Found" represents 57 cases and are included under "Other."

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, St. Louis: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	8,568	48.0
Cocaine	2,642	14.8
Heroin	2,069	11.6
Methamphetamine	659	3.7
1-Benzylpiperazine	419	2.3
Hydrocodone	374	2.1
Alprazolam	366	2.1
Oxycodone	266	1.5
3,4-Methylenedioxy-methamphetamine	219	1.2
Pseudoephedrine	217	1.2
Other <sup>2</sup>	2,052	11.5
<b>Total</b>	<b>17,851</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data are for the St. Louis MO/IL MSA, which includes the City of St. Louis and 16 counties: St. Louis, St. Charles, St. Francis, Jefferson, Franklin, Lincoln, Warren, and Washington Counties in Missouri; and Madison, St. Clair, Macoupin, Clinton, Monroe, Jersey, Bond, and Calhoun Counties in Illinois.

2. "No Drug Found" represents 917 cases and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 24, 2010

**Appendix Table 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Diego: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	10,828	51.7
Methamphetamine	4,220	20.2
Cocaine	1,961	9.4
Heroin	781	3.7
Hydrocodone	447	2.1
3,4-Methylenedioxy-methamphetamine	396	1.9
Oxycodone	321	1.5
Alprazolam	189	0.9
Diazepam	121	0.6
Clonazepam	111	0.5
Other <sup>2</sup>	1,566	7.5
<b>Total</b>	<b>20,941</b>	<b>100.0</b>

<sup>1</sup>January 2008–December 2008.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data are for San Diego County.

2. "Noncontrolled Nonnarcotic Drug" represents 487 cases and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: First Half of CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	4,245	27.1
Cocaine	3,857	24.6
Methamphetamine	3,398	21.7
Heroin	711	4.5
3,4-Methylenedioxy-methamphetamine	658	4.2
Hydrocodone	441	2.8
Oxycodone	426	2.7
Methadone	194	1.2
Morphine	156	1.0
Clonazepam	137	0.9
Other <sup>2</sup>	1,436	9.2
<b>Total</b>	<b>15,659</b>	<b>100.0</b>

<sup>1</sup>Data are for the first half of 2009 only: January 2009–July 2009.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data are for the San Francisco/Oakland/Fremont MSA: Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.

2. "No Drug Found" represents 590 cases and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 24, 2010

**Appendix Table 2.20. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	922	35.2
Cocaine	627	23.9
Methamphetamine	292	11.2
Heroin	217	8.3
Oxycodone	180	6.9
3,4-Methylenedioxy-methamphetamine	66	2.5
1-Benzylpiperazine	62	2.4
Buprenorphine	39	1.5
Hydrocodone	32	1.2
Alprazolam	26	1.0
Other <sup>2</sup>	155	5.9
<b>Total</b>	<b>2,618</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

## NOTES:

1. Data are for King County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.21. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cannabis	32,482	31.5
Cocaine	29,797	28.9
Methamphetamine	12,158	11.8
Alprazolam	4,755	4.6
Hydrocodone	4,017	3.9
Heroin	3,160	3.1
3,4-Methylenedioxy-methamphetamine	1,910	1.9
1-Benzylpiperazine	1,565	1.5
Carisoprodol	1,081	1.0
Clonazepam	864	0.8
Other <sup>2</sup>	11,296	11.0
<b>Total</b>	<b>103,085</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for the State of Texas.

2. "No Drug Found" represents 1,717 cases and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

**Appendix Table 2.22. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: CY 2009<sup>1</sup>**

Drug	Number	Percentage
Cocaine	1,454	41.3
Cannabis	1,186	33.7
Heroin	352	10.0
Phencyclidine	209	5.9
1-Benzylpiperazine	63	1.8
Methamphetamine	51	1.4
1-(3-Trifluoromethyl-phenyl)Piperazine	30	0.9
Buprenorphine	30	0.9
Oxycodone	28	0.8
3,4-Methylenedioxy-methamphetamine	25	0.7
Other <sup>2</sup>	92	2.6
<b>Total</b>	<b>3,520</b>	<b>100.0</b>

<sup>1</sup>January 2009–December 2009.<sup>2</sup>All other analyzed items.

NOTES:

1. Data are for the District of Columbia only.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, April 26, 2010

# Participant List

**National Institute on Drug Abuse  
Community Epidemiology Work Group Meeting**  
*The Radisson Hotel Boston  
Boston, Massachusetts  
June 9–11, 2010*

**Cynthia L. Arfken, Ph.D.**

Associate Professor  
Wayne State University  
2761 East Jefferson Avenue  
Detroit, MI 48207  
Phone: 313–993–3490  
Fax: 313–577–5062  
E-mail: [carfken@med.wayne.edu](mailto:carfken@med.wayne.edu)

**Erin Artigiani, M.A.**

Deputy Director for Policy  
Center for Substance Abuse Research  
University of Maryland  
Suite 501  
4321 Hartwick Road  
College Park, MD 20740  
Phone: 301–405–9794  
Fax: 301–403–8342  
E-mail: [erin@cesar.umd.edu](mailto:erin@cesar.umd.edu)

**Caleb Banta-Green, Ph.D., M.P.H., M.S.W.**

Research Scientist  
Alcohol and Drug Abuse Institute  
University of Washington  
Suite 120  
1107 N.E. 45th Street  
Seattle, WA 98105  
Phone: 206–685–3919  
Fax: 206–543–5473  
E-mail: [calebbg@uw.edu](mailto:calebbg@uw.edu)

**Annie Millar Biggs, Ph.D.**

Senior Policy Analyst  
Office of National Drug Control Policy  
Executive Office of the President  
Room 534  
750 17th Street, N.W.  
Washington, DC 20503  
Phone: 202–395–5504  
Fax: 202–395–5571  
E-mail: [amillar@ondcp.eop.gov](mailto:amillar@ondcp.eop.gov)

**Edward W. Boyer, M.D., Ph.D.**

Professor  
Department of Emergency Medicine  
University of Massachusetts Medical School  
55 Lake View  
Worcester, MA 01655  
Phone: 508–421–1400  
Fax: 508–421–1490  
E-mail: [edward.boyer@childrens.harvard.edu](mailto:edward.boyer@childrens.harvard.edu)

**Mary-Lynn Brecht, Ph.D.**

Research Statistician  
Integrated Substance Abuse Programs  
University of California, Los Angeles  
Suite 200  
1640 South Sepulveda Boulevard  
Los Angeles, CA 90025  
Phone: 310–267–5275  
Fax: 310–473–7885  
E-mail: [lbrecht@ucla.edu](mailto:lbrecht@ucla.edu)



**Jane Buxton, M.B.B.S., M.H.Sc.**

Physician Epidemiologist  
 BC Centre for Disease Control  
 University of British Columbia  
 655 West 12th Avenue  
 Vancouver, British Columbia V5Z 4R4  
 Canada  
 Phone: 604-707-2573  
 Fax: 604-707-2516  
 E-mail: [jane.buxton@bccdc.ca](mailto:jane.buxton@bccdc.ca)

**M. Fe Caces, Ph.D.**

Statistician/Demographer  
 Office of National Drug Control Policy  
 Executive Office of the President  
 Room 534  
 750 17th Street, N.W.  
 Washington, DC 20503  
 Phone: 202-395-3173  
 Fax: 202-395-6562  
 E-mail: [mcaces@ondcp.eop.gov](mailto:mcaces@ondcp.eop.gov)

**David Cavanagh, Ph.D.**

Epidemiologist  
 Massachusetts Department of Public Health  
 250 Washington Street  
 Boston, MA 02108  
 Phone: 617-624-5096  
 E-mail: [david.cavanagh@state.ma.us](mailto:david.cavanagh@state.ma.us)

**Tom Clark**

Research Associate  
 PMP Center of Excellence  
 Brandeis University  
 Waltham, MA 02453  
 Phone: 781-736-9340  
 E-mail: [twclark@brandeis.edu](mailto:twclark@brandeis.edu)

**Karyn Bjornstad Collins, M.P.A.**

CEWG Technical Editor  
 Social Solutions International, Inc.  
 441 Keith Avenue  
 Missoula, MT 59801  
 Phone: 406-370-9931  
 E-mail: [kcollins@socialsolutions.biz](mailto:kcollins@socialsolutions.biz)

**Wilson Compton, M.D., M.P.E.**

Director  
 Division of Epidemiology, Services and  
 Prevention Research  
 National Institute on Drug Abuse  
 National Institutes of Health  
 6001 Executive Boulevard  
 Bethesda, MD 20892  
 Phone: 301-443-6504  
 Fax: 301-443-2636  
 E-mail: [wcompton@nida.nih.gov](mailto:wcompton@nida.nih.gov)

**James K. Cunningham, Ph.D.**

Social Epidemiologist  
 Department of Family and Community  
 Medicine  
 College of Medicine  
 University of Arizona  
 1450 North Cherry Avenue  
 Tucson, AZ 85719  
 Phone: 520-615-5080  
 Fax: 520-577-1864  
 E-mail: [jkcunin@email.arizona.edu](mailto:jkcunin@email.arizona.edu)

**Samuel J. Cutler**

Program Manager  
 Drug and Alcohol Abuse  
 Department of Behavioral Health and  
 Mental Retardation Services  
 Office of Addiction Services  
 City of Philadelphia  
 Suite 800  
 1101 Market Street  
 Philadelphia, PA 19107  
 Phone: 215-685-5414  
 Fax: 215-685-4977  
 E-mail: [sam.cutler@phila.gov](mailto:sam.cutler@phila.gov)

**Lara DePadilla, Ph.D.**

Visiting Assistant Professor  
 Department of Behavioral Sciences and Health  
 Education  
 Rollins School of Public Health  
 Emory University  
 Floor 5  
 1518 Clifton Road  
 Atlanta, GA 30322  
 Phone: 404-358-5037  
 Fax: 404-727-1369  
 E-mail: [ldepadi@emory.edu](mailto:ldepadi@emory.edu)

**Kristen A. Dixon, M.A., L.P.C.**

Evaluation Researcher  
 Division of Behavioral Health  
 State of Colorado  
 3824 West Princeton Circle  
 Denver, CO 80236  
 Phone: 303-866-7407  
 Fax: 303-866-7428  
 E-mail: [kristen.dixon@state.co.us](mailto:kristen.dixon@state.co.us)

**Daniel P. Dooley**

Senior Researcher  
 Boston Public Health Commission  
 Floor 6  
 1010 Massachusetts Avenue  
 Boston, MA 02118  
 Phone: 617-534-2360  
 Fax: 617-534-2424  
 E-mail: [ddooley@bphc.org](mailto:ddooley@bphc.org)

**Carol L. Falkowski**

Director  
 Alcohol and Drug Abuse Division  
 Minnesota Department of Human Services  
 540 Cedar Street  
 St. Paul, MN 55115  
 Phone: 651-431-2457  
 Fax: 651-431-7449  
 E-mail: [carol.falkowski@state.mn.us](mailto:carol.falkowski@state.mn.us)

**Paul Griffiths, M.Sc.**

Scientific Coordinator  
 European Monitoring Centre for Drugs and  
 Drug Addiction  
 Cais do Sodré  
 Lisbon, Portugal 1249-289  
 Phone: 351-211-210-206  
 Fax: 351-213-584-441  
 E-mail: [paul.griffiths@emcdda.europa.eu](mailto:paul.griffiths@emcdda.europa.eu)

**James N. Hall**

Director  
 Center for the Study and Prevention of  
 Substance Abuse  
 Nova Southeastern University  
 c/o Up Front, Inc.  
 13287 S.W. 124th Street  
 Miami, FL 33186  
 Phone: 786-242-8222  
 Fax: 786-242-8759  
 E-mail: [upfrontin@aol.com](mailto:upfrontin@aol.com)

**Heidi Israel, Ph.D., R.N., F.N.P., L.C.S.W.**

Assistant Professor  
 Department of Orthopaedic Surgery  
 St. Louis University  
 School of Medicine  
 3625 Vista, FDT-7N  
 St. Louis, MO 63110  
 Phone: 314-577-8851  
 Fax: 314-268-5121  
 E-mail: [israelha@slu.edu](mailto:israelha@slu.edu)

**Rozanne Marel, Ph.D.**

Assistant Chief of Epidemiology  
 New York State Office of Alcoholism and  
 Substance Abuse Services  
 9th Floor  
 501 Seventh Avenue  
 New York, NY 10018  
 Phone: 646-728-4605  
 Fax: 646-728-4685  
 E-mail: [rozannemarel@oasas.state.ny.us](mailto:rozannemarel@oasas.state.ny.us)

**Jane C. Maxwell, Ph.D.**

Senior Research Scientist  
 Addiction Research Institute  
 Center for Social and Behavioral Research  
 The University of Texas, Austin  
 Suite 335  
 1717 West 6th Street  
 Austin, TX 78703  
 Phone: 512-232-0610  
 Fax: 512-232-0617  
 E-mail: [jcmaxwell@sbcglobal.net](mailto:jcmaxwell@sbcglobal.net)

**Corinne P. Moody**

Science Policy Analyst  
 Food and Drug Administration  
 Building 51, Room 5144  
 10903 New Hampshire Avenue  
 Silver Spring, MD 20993  
 Phone: 301-796-3152  
 Fax: 301-847-8736  
 E-mail: [corinne.moody@fda.hhs.gov](mailto:corinne.moody@fda.hhs.gov)

**Jason Mullen, M.A.**

Intelligence Research Specialist  
 Drug Enforcement Administration  
 U.S. Department of Justice  
 Floor 17  
 255 East Temple Street  
 Los Angeles, CA 90012  
 Phone: 213-621-6981  
 Fax: 213-576-2378  
 E-mail: [jason.r.mullen@usdoj.gov](mailto:jason.r.mullen@usdoj.gov)

**Susanna Nemes, Ph.D.**

President and Chief Executive Officer  
 Social Solutions International, Inc  
 8070 Georgia Avenue, Suite 201  
 Silver Springs, MD 20910  
 Phone: 301-775-4257  
 Fax: 301-570-4772  
 E-mail: [snemes@socialsolutions.biz](mailto:snemes@socialsolutions.biz)

**John Newmeyer, Ph.D.**

Epidemiologist  
 HIV Prevention Planning Council  
 2004 Gough Street  
 San Francisco, CA 94109  
 Phone: 415-710-3632  
 Fax: 415-776-8823  
 E-mail: [jnewmeyer@aol.com](mailto:jnewmeyer@aol.com)

**Rita Nieves, RN, M.P.H. M.S.W.**

Director  
 The Addictions Prevention, Treatment and  
 Recovery Support Services Bureau  
 Boston Public Health Commission  
 2nd Floor  
 774 Albany Street  
 Boston, MA 02118  
 Phone: 617-534-7069  
 E-mail: [rita\\_nieves@bphc.org](mailto:rita_nieves@bphc.org)

**Moir P. O'Brien, M.Phil.**

Health Scientist Administrator  
 Epidemiology Research Branch  
 Division of Epidemiology, Services and  
 Prevention Research  
 National Institute on Drug Abuse  
 National Institutes of Health  
 Room 5153, MSC-9589  
 6001 Executive Boulevard  
 Bethesda, MD 20892  
 Phone: 301-402-1881  
 Fax: 301-443-2636  
 E-mail: [mobrien@nida.nih.gov](mailto:mobrien@nida.nih.gov)

**Lawrence Ouellet, Ph.D.**

Research Professor  
 Division of Epidemiology and Biostatistics  
 School of Public Health  
 University of Illinois at Chicago  
 Mailcode 923  
 1603 West Taylor Street  
 Chicago, IL 60612  
 Phone: 312-355-0145  
 Fax: 312-996-1450  
 E-mail: [ljo@uic.edu](mailto:ljo@uic.edu)

**Artisha R. Polk, M.P.H.**

Mathematical Statistician  
Office of Diversion Control/ODE  
Drug Enforcement Administration  
U.S. Department of Justice  
8701 Morrisette Drive  
Springfield, VA 22152  
Phone: 202-307-7180  
Fax: 202-353-1263  
E-mail: [artisha.r.polk@usdoj.gov](mailto:artisha.r.polk@usdoj.gov)

**Robin Pollini, Ph.D., M.P.H.**

Assistant Professor  
University of California, San Diego  
Mail Code 0507  
9500 Gilman Drive  
La Jolla, CA 92093  
Phone: 858-534-0710  
Fax: 858-534-7566  
E-mail: [rpollini@ucsd.edu](mailto:rpollini@ucsd.edu)

**Cassandra Prioleau, Ph.D.**

Drug Science Specialist  
Drug Enforcement Administration  
U.S. Department of Justice  
8701 Morrisette Drive  
Springfield, VA 22152-2490  
Phone: 202-307-7254  
Fax: 202-353-1263  
E-mail: [cassandra.prioleau@usdoj.gov](mailto:cassandra.prioleau@usdoj.gov)

**Sandra Putnam, M.Sc., Ph.D.**

CEWG Project Director  
Social Solutions International, Inc.  
1541 Stewartstown Road  
Morgantown, WV 26505  
Phone: 304-292-5148  
Fax: 304-292-5149  
E-mail: [sputnam@socialsolutions.biz](mailto:sputnam@socialsolutions.biz)

**Natania Oliva Robles**

Psychologist  
National Institute of Psychiatry Ramon  
de la Fuente Muñiz  
Calzada Mexico-Xochimilco 101  
Col. San Lorenzo Huipulco  
Mexico City, DF 14370  
Mexico  
Phone: 52-640-8752  
Fax: 55-5907-7009  
E-mail: [natania@imp.edu.mx](mailto:natania@imp.edu.mx)

**Christopher Rosenbaum, M.D.**

Division of Medical Toxicology  
Department of Emergency Medicine  
University of Massachusetts Medical Center  
55 Lake Avenue North, LA-215  
Worcester, MA 01655  
Phone: 508-421-1463  
Fax: 508-421-1490  
E-mail: [crosen5@gmail.com](mailto:crosen5@gmail.com)

**Jan Scaglione, M.T., Pharm.D.,  
DABAT**

Clinical Toxicologist  
Cincinnati Drug and Poison Information  
Center  
ML-9004  
3333 Burnet Avenue  
Cincinnati, OH 45229  
Phone: 513-636-5060  
Fax: 513-636-5072  
E-mail: [jan.scaglione@cchmc.org](mailto:jan.scaglione@cchmc.org)

**Susan A. Seese, Ph.D.**

Senior Intelligence Analyst/SENTRY  
Program Manager  
National Drug Intelligence Center  
U.S. Department of Justice  
Fifth Floor  
319 Washington Street  
Johnstown, PA 15901  
Phone: 814-532-4093  
Fax: 814-532-5858  
E-mail: [susan.seese@usdoj.gov](mailto:susan.seese@usdoj.gov)

**Judy Snider, M.Sc.**

Manager of Surveillance  
Office of Drugs and Alcohol Research  
and Surveillance  
Controlled Substances and Tobacco  
Directorate  
Healthy Environments and Consumer  
Safety Branch  
Health Canada  
MacDonald Building, A.L. 3506D  
123 Slater Street  
Ottawa, Ontario K1A 0K9  
Canada  
Phone: 613-952-2514  
Fax: 613-952-5188  
E-mail: [judy.snider@hc-sc.gc.ca](mailto:judy.snider@hc-sc.gc.ca)

**Marcella H. Sorg, Ph.D., R.N., D-ABFA**

Director  
Rural Drug and Alcohol Research Program  
Margaret Chase Smith Policy Center  
University of Maine  
Building 4  
5784 York Complex  
Orono, ME 04469  
Phone: 207-581-2596  
Fax: 207-581-1266  
E-mail: [marcella.sorg@umit.maine.edu](mailto:marcella.sorg@umit.maine.edu)

**Margriet van Laar, Ph.D.**

Program Director, Drug Monitoring  
Coordinator, National Drug Monitor/Focal  
Point  
Trimbos Institute  
Da Costakade 45  
P.O. Box 725,  
3500 AS Utrecht  
The Netherlands  
Phone: 31-30-297-11-00  
Fax: 31-30-297-11-11  
E-mail: [mlaar@trimbos.nl](mailto:mlaar@trimbos.nl)

**Jorge A. Villatoro Velázquez, M.C.**

Researcher  
National Institute of Psychiatry Ramon  
de la Fuente Muñiz  
Calzada Mexico-Xochimilco 101  
Col San Lorenzo-Huipulco  
Mexico City, DF 14370  
Mexico  
Phone: 52-4151-5201  
Fax: 55-5513-3446  
E-mail: [ameth@imp.edu.mx](mailto:ameth@imp.edu.mx)

**Chris Wilkins, Ph.D.**

Senior Researcher  
Drugs Team Leader  
Centre for Social and Health Outcomes  
Research and Evaluation (SHORE)  
Massey University  
P.O. Box 6137  
Wellesley Street  
Auckland, New Zealand  
Phone: 64-9-366-6136  
Fax: 64-9-366-5149  
E-mail: [C.Wilkins@massey.ac.nz](mailto:C.Wilkins@massey.ac.nz)

**Eric D. Wish, Ph.D.**

Director  
Center for Substance Abuse Research  
University of Maryland  
4321 Hartwick Road, Suite 501  
College Park, MD 20740  
Phone: 301-405-9774  
Fax: 301-403-8342  
E-mail: [ewish@cesar.umd.edu](mailto:ewish@cesar.umd.edu)

**D. William Wood, M.P.H., Ph.D.**

Professor and Chair  
Department of Sociology  
University of Hawaii at Manoa  
Room 247  
2424 Maile Way  
Honolulu, HI 96822  
Phone: 808-956-7693  
Fax: 808-956-3707  
E-mail: [dwwood@hawaii.edu](mailto:dwwood@hawaii.edu)

**May Yamate, M.S.**

Westat

1600 Research Blvd.

Rockville, MD 20850

Phone: 240-314-7586

Fax: 301-610-5140

E-mail: [mayyamate@westat.com](mailto:mayyamate@westat.com)

**Meeting Coordinator**

**Patricia Evans**

Conference Manager

Knowledge Translation and Strategic

Communication Division

RTI International

Suite 415

6110 Executive Boulevard

Rockville, MD 20852

Phone: 301-816-4612

Fax: 301-770-8205

E-mail: [pevans@rti.org](mailto:pevans@rti.org)



NIDA

NATIONAL INSTITUTE  
ON DRUG ABUSE

April 2011

U.S. Department of Health and Human Services  
National Institutes of Health